Hampshire Safeguarding Adults Board

Safeguarding Adult Review Policy and Toolkit

June 2020

(Review Date: June 2022)

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 of a Safeguarding Adult Review or Discretionary Review, as well as providing guidance on the 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 and Discretionary Reviews are commissioned and managed by the Hampshire Safeguarding Adults Board and are only undertaken in circumstances involving the death or serious injury of an adult with care and support needs and where the death was known to have been caused or suspected to have been caused or contributed to by abuse or neglect.

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Section One Safeguarding Adults Review Policy

1.0 Introduction

1.1 The Care Act 2014 came into force in April 2015 and created a legal framework for Adult Safeguarding. Section 44 of the Act requires local safeguarding adult boards (SAB) to arrange a safeguarding adult review (SAR) when a case involves 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.

(4) An SAB may arrange for there to be a review of any other 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).

1.2 The Care Act 2014 also enables SABs to carry out discretionary SARs or other reviews in cases which do not necessarily meet the statutory criteria but 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.

1.3 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.

1.4 The Policy outlined in this document reflects and builds on the six safeguarding principles outlined in the Care Act 2014. 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
Empowerment	Presumption of person led decisions and informed consent
Prevention	It is better to take action before harm occurs
Proportionality	Proportionate and least intrusive responses appropriate to risks
Protection	Support and representation for those in greatest need
Partnership	Local solutions through services working with their communities
Accountability	Accountability and transparency in delivering safeguarding

2.0 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 multi-agency child practice reviews) 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 and the value to the local safeguarding system of the anticipated learning. Due to the opportunity for learning, there is a presumption that safeguarding adults reviews will be published, unless exceptional circumstances are present. This would need to be considered by the Learning and Review Subgroup and authorised by the independent board chair.

- The safeguarding adult review should be conducted by an independent author who is commissioned by the Hampshire Safeguarding Adults Board, with representation from agencies involved in the case under review.

- 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 safeguard the person at risk and to identify any actions needed to improve future practice, systems 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, and to the contextual factors that were influencing their performance and decision making. 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.

3.0 The purpose of a safeguarding adult review

3.1 The purpose of conducting a safeguarding adult review is to draw out the learning for the safeguarding system from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk. Specifically, the purpose of the safeguarding adult review is to:

- Understand what happened within the period under review and why it happened
- Determine whether anything might have been done differently to reduce the likelihood of similar outcomes re-occurring;
- 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 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.

4.0 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 for the safeguarding system. 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 or effective systems working where this is likely to identify lessons that can be applied to future cases.

4.3 The HSAB Methodologies Menu for Reviews and also the HSAB Safeguarding Adult Methodology Pathway will be referred to by the Learning and Review Subgroup to support appropriate decision making.

5.0 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 The person and/or their representative 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.

5.6 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.

5.7 To make a referral for a multi-agency review, the referral form at the following link should be completed and submitted to the HSAB Learning and Review Subgroup: https://www.hampshiresab.org.uk/wp-content/uploads/HSAB-Multi-Agency-Review-Referral-Form.docx

6.0 Decision-making

6.1 The Learning and Review Subgroup will refer to the jointly agreed Terms of Reference (which is updated annually). As such, each referral will be considered by the Board Manager and the Learning and Review Subgroup Chair (or in their absence, deputy chair) for consideration of initiation of scoping request from those agencies which have been identified so far in the case. 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 deciding whether or not to commission a safeguarding adult review, advised by the recommendation of the Learning and Review Subgroup. The Learning and Review subgroup is made up of representatives of the three statutory agencies (Local Authority, Police and CCG), who have a particular responsibility to agree on the recommendation to the Board Chair. They are supported in their deliberations by representatives of other key local agencies who sit on the group.

6.2 If it is considered that the case meets the criteria for a safeguarding adult review, the independent Chair of the Board will delegate the responsibility of commissioning the Safeguarding Adults Review on behalf of the Hampshire Safeguarding Adults Board. This includes consideration of the most appropriate methodology to use either the traditional method or the systems learning approach; alternatively a hybrid model incorporating both methodologies may be appropriate. This approach will be confirmed between the learning and review subgroup and the independent safeguarding adults review author.

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 and also discretionary reviews are statutory processes as defined by The Care Act (2014) for cases meeting specific criteria.

6.5 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.

7.0 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. 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.

7.2 There may be criminal or coronial investigations running concurrently with the Safeguarding Adult Review. If appropriate, steps should be taken to ensure the adult is safe and provided the relevant support. Any proposals for a SAR must ensure that they do not prejudice criminal or judicial proceedings. In cases where criminal proceedings may follow the death or serious injury of an adult, the LRS Chair should discuss how the review process should take account of such proceedings with the relevant criminal justice agencies (such as the police and the CPS) at an early stage. Consideration should be given to, for example, effects on timing, the way in which the review is conducted (including any interviews of relevant personnel), what the potential impact on criminal investigations is and who should contribute at what stage? Work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings. In particular it is essential that the SAR reviewer liaises closely with the relevant senior investigating officer from the other agencies concerned to make sure that professionals and members of the public that are likely to be called at a witness trial are not compromised by the activity of the review. It may also be necessary to delay the publishing of overview reports until the conclusion of any criminal trial. Individual agencies can however progress with implementing the learning from the review.

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. 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 separate from 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.

8.0 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 in a written report (the IMR). The collated findings of the analysis undertake across the agencies then forms 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. This approach sets out to study the whole system and look closely at the contextual factors that influenced professional practice. The process then develops generic findings with a wider application as opposed to findings that relate to the one case under review. The process is a collaborative process with professionals being actively involved in the review from the outset. There are also other methodologies such as Serious Incident Learning Process (SILP) which uses a round the table meeting with the professionals involved to assist in drawing out the case learning.

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.

9.0 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, developing the action plan and agreeing sign off of the report for publication. The national SAR Quality Markers are used as prompts to support good practice.

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 maintaining an oversight and co-ordination role throughout the process including providing a quality assurance. The Learning and Review Subgroup is also responsible for quality assuring 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 led by a reviewer who is 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:

- Strong leadership and ability to motivate others
- Inclined towards promoting an open, reflective learning culture
- Facilitation skills
- 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.

9.6 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.

9.7 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 where ever possible 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 s68 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 the person and their representative(s)

11.1 It is vital that the person or their family/representative are made aware that the review is taking place and offered the opportunity of contributing to the review process. The Learning and Review Subgroup Chair and the Independent Reviewer will agree who is best placed to contact the person or their family/representative. Once this has been decided, they will be contacted and invited to participate in the review process. However, 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.

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 should aim to report within six months of the review being established. The recommendations are to be developed by the safeguarding adults review panel, supported by the independent reviewer. 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 and also the national Safeguarding Adult Review Library 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 Learning and Review Subgroup will complete an evaluation detailing the outcomes a result of the actions undertaken from the review. 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 Health and Care 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 action plan. The Website can be viewed via this link www.hampshiresab.org.uk

Section Two: Safeguarding Adult Review Toolkit

1.0 Overview of the process

The Safeguarding Adult Review Panel

The Chair of the HSAB 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. The Overview Report Author will be independent. The Panel Chair will also be independent or be co-opted from an adjoining Authority where there is no conflict of interest.

A Safeguarding Adult Review Panel (hereafter referred to as 'Review Panel') will also be commissioned consisting of at least Health, Police and Local Authority representatives. The Chair of the HSAB will write to the Chief Officers of the organisations involved for nominations to the Review Panel and will request the production of a full chronology of agency involvement and Individual Management Reviews or IMRs (See 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 Subgroup will consider the need for relevant subject experts such as substance misuse, domestic abuse, mental health or medical experts.

2.0 Terms of Reference

The Learning and Review Subgroup 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 Review Panel (See Appendix 1 for Terms of Reference Template). Terms of Reference will include the following:

- Details of the subject and details of concerns that triggered the safeguarding adult review
- Agencies required to provide IMRs
- Membership of Panel, Independent Author and Chair
- Key areas to be considered as part of the review
- How the safeguarding adult review will link with any parallel processes and/or criminal or Coroner's investigations and considerations of these

It is important that the Review Panel decides 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.

3.0 Chronologies and Individual Management Reviews

Using this approach, agencies will be asked to produce a chronology and an IMR.

The chronology and IMR are a vital part of the review process and therefore it is essential that authors are supported by their agencies in carrying out this function.

At the beginning, the Review Panel will convene a meeting between itself and IMR authors to go through the process and expectations of the IMRs.

During the review the Review Panel will ask IMR 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 Review Panel Chair will convene a meeting of the IMR authors to debrief them about the findings.

A template to be used as standard for the production of chronologies and IMRs in contained in Appendix 2 & 3.

4.0 Responsibilities of the Safeguarding Adult Review Panel

The role of the 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 Review Panel members will attend each Panel meeting. Each Review 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 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 Review Panel meetings and that there is continuity.

Once the 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 Review Panel Chair or Overview Report Author may require.

The Review Panel will be quorate when the police, health and local authority representatives are present, together with the Chair and will meet on average between 3 and 6 times during the course of the review.

Section Three: Safeguarding Adult Reviews using the SCIE systems learning approach

Introduction

'Systems Learning' is a multi-agency systems approach which studies the wider safeguarding system and looks 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. It appraises professional practice in the case and moves forward to understand what the case tells us about the functioning of the safeguarding system.

It is a collaborative process with professionals being actively involved in the review from the outset. The methodology supports 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

The process use Research Questions in place of the more traditional Terms of Reference which are set by the SAB Chair and Learning and Review group in collaboration with the Lead Reviewer. The Research Questions provide a framework for the review, and highlight the particular areas of learning across the system that is wanted by the SAB.

The Final Report sets out system based findings and raises questions for the Board to consider, which then support the process of action planning.

Process

Agreeing the Lead Reviewers and Review Panel

The Learning and Review Subgroup will decide on undertaking the Safeguarding Adult Review using "Learning Together" methodology and contact SCIE who will be able to source an accredited Lead Reviewer. The Chair of the Safeguarding Adults Board will appoint the Reviewer. Using the SCIE model can involve one or two Lead Reviewers, one will always be an independent person. The second reviewer may be an internal person (i.e. an employee of one of the local agencies).

At the scoping meeting there will be an early consideration of developing a shared chronology and sharing of documentation. The Lead Reviewer is supported in the analysis work by one representative from each agency who will join the Review Team and participate as a key member of the process. At the scoping 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.

The Review Team are the multi-agency group of people conducting the review with the Lead Reviewer and are usually middle and/or strategic managers, who can bring their knowledge of the local system and services.

The Case Group is made up of frontline staff and their immediate line managers who were directly involved with the family in question (see Part B appendix 2 for invite letters) during the period under review. The case group are invited to participate in the one day learning workshop and may also be invited to be interviewed.

There will be a briefing for all staff involved to ensure they have a chance to learn about the process and the model and to ask any questions before the one day leaning workshop.

The one-day Learning Workshop

In some cases it is useful for the Lead Reviewer and a member of the Review Team to undertake a small number of individual interviews (known as conversations) with key front line staff.

The one day workshop is for the Case group to attend and members of the Review Team. The workshop draws out the data from staff who were involved, about the period under review, and seeks to explore the contributory factors that influenced their practice and decisions at the time. The workshop also explores the emerging patterns and themes.

Meetings with the Review Team

There will be one or two half day meetings held with the Review Team to support the development of (a) the appraisal of professional practice and (b) the generic systems findings. The report is developed by the Lead Reviewer with contributions from the Review Team member.

The review report

The Lead Reviewer uses a template produced by SCIE to support the methodology which includes generic findings and questions for the board (which are used in place of the more traditional recommendations).

Hampshire Safeguarding Adults Board Presentation

The report is presented to the Hampshire Safeguarding Adults Board by the Lead Reviewers. The report questions act as a link between the findings and the process of action planning, allowing the Board to think about what their learning priorities are. The Board then develop the response and agree priorities.

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

Each 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 Panel Chair to convey any urgent learning points emerging from the 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 Review Panel will confirm:

- The detailed terms of reference and if necessary ask for clarification from the Learning and Review Subgroup Chair.

- The information required from each participant.

- The support and other resources needed, any perceived deficits to be referred to the Learning and Review Subgroup Chair.

- Dates, times and venues for meetings.

- The nature and extent of legal information required, in particular any Data Protection considerations.

- Confirmation of who will be responsible for liaising with family members and when this should be undertaken within the process. This is usually the Panel Chair and one other panel member.

A safeguarding adult review is a forum for formal information sharing and all members of the Review Panel will be expected to critically analyse all the information presented.

Subsequent meetings of the panel will receive the IMR, request any additional information or seek necessary clarifications.

On the basis of the above analysis, the 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 Review Panel will formulate 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 Review Panel will meet to consider, amend as necessary and ratify the Overview Report prior to its submission to the Learning and Review Subgroup Chair.

The final Overview Report and Executive Summary will be forwarded to the Safeguarding Adults Board Chair 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 Subgroup to monitor the implementation of action plans.

Responsibilities of the Safeguarding Adults Board

The Safeguarding Adults Board will consider the final draft of the Overview Report and will either agree it and its recommendations or return it to the Author for further work (supported by the Learning and Review Subgroup). Once the SAB has agreed the Overview Report, it will:

- 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 Report will then be published. It has been agreed that the norm will be to publish a full anonymised version of the report.

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

APPENDIX A Pathway for conducting a Safeguarding Adult Review

Safeguarding Adult Review Referral Process

- Written request for Safeguarding Adult Review submitted to Learning and Review Subgroup using the online referral form.
- Review of referral by Learning and Review Subgroup Chair (or Deputy) for consideration of scoping.
- Decision maker to formally write to the referrer to detail the next steps.
- If accepted as a referral, the board will request that agencies involved with case supply scoping information in the form of a chronology.
- The referral and scoping information is then reviewed by the Learning and Review Subgroup for consideration of a Safeguarding Adult Review or Discretionary Review.
- Learning and Review Subgroup makes recommendations to HSAB Chair on its decision.
- Learning and Review Subgroup identified an independent reviewer, methodology and timescales.
- Chair notifies Hampshire Safeguarding Adults Board and Care Quality Commission if registered services involved.
- HSAB Learning and Review Subgroup Chair or Independent Reviewer contacts the person/family.

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 seeks Review Panel/Team Members and confirms involved lead representative.
- The SAR process is undertaken including engagement with the person/family and front line staff. Findings and recommendations are produced and presented to the SAB to facilitate action planning.
- The review author reports to the Learning and Review Sub-group who will complete the quality assurance process. The Sub-Group will then report to the Hampshire Safeguarding Adults Board.

Publication

- Feedback sessions with staff, the person, and representative facilitated by the SAB Board Manager.

- Final Report published.

Review and Monitoring

- Action plans to be monitored by the Learning and Review Subgroup in combination with other relevant subgroups of the board as appropriate to ensure the learning supports the development of frontline practice.

APPENDIX B 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 adults at risk 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 adults at risk safe.

What is a Safeguarding Adult Review?

The Hampshire Safeguarding Adults Board may carry out a Safeguarding Adult Review when an adult at risk 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 adult(s) at risk 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 adult at risk. 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

APPENDIX C Referral Form for a Multi-Agency Review

Hampshire Safeguarding Adults Board

Referral Form for a Multi Agency Review

Please use this form to request a Multi-Agency Review for consideration by the Learning and Review Sub-Group.

All notifications should have been discussed with senior managers in your agency beforehand.

In urgent situations, particularly if there is significant media interest, please make contact by email HSAB@hants.gov.uk and then complete and return this form.

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.

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?

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.

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 form:

Please provide the following information in full and send the form to: HSAB@hants.gov.uk

No.	Information required	Details
1	Name of Adult	
2	Gender	
3	Client/Incident Reference Number (If Applicable)	
4	Address	
5	Date of birth (or Age if DOB unknown)	
6	Date of incident and cause of death (if applicable)	
7	GP contact details	
8	Family contact details	
9	Are the adult's family aware of this referral?	
10	Agencies involved with the person	
11	Brief details of the of the case	
12	Did the person have care and support needs?	
13	Was the Adult subject to a Section 42 Safeguarding enquiry at the time of the incident?	

14	Has this incident been referred to another body?	
15	Are there on-going criminal proceedings?	
16	Details of any internal review or investigation carried out	
17	Please state why you consider criteria for a multi-agency review to be met in this case	
18	Please provide any additional information which may be useful	

Referrer details

Information required	**Details**
Referrer's name	
Job title	
Employed by	
Address	
Email	
Telephone	
If a commissioned service, please state if the commissioner been informed of this referral	
Please state if your agency's HSAB representative has been made aware of this referral	

Please read the following information regarding the HSAB decision making with regards to your submission.

Criteria for conducting a statutory Safeguarding Adult Review (SAR)

The SAB must arrange a SAR 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.

HSAB Decision Making

If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. Serious Incident Requiring Investigation, Critical Incident Review, etc.), this should take place without delay and in line with the organisation's internal policy requirements.

A referral for a SAR should be a considered decision, informed by consideration and evaluation of all relevant information by the professionals involved in the specific case.

The following decision-making criteria will be used to assess all SAR referrals:

• Concerns relate to a person with needs of care and support – whether or not in receipt of services at the time of death or injury.
• Cause of death has been established.
• Any safeguarding enquiry process has concluded.
• Evidence of a causal link between the death and abuse, neglect or acts of omission.
• The harm caused or death is judged to have been preventable.
• Concerns exist about the way partners worked together to safeguard the adult.
• Concerns relate to systemic failings relating to multiple organisations.
• There is potential to identify learning to improve the local safeguarding system, multi-agency practice and partnership working.
• The SAR will add value to any investigations or reviews already carried out and will not duplicate.
• In cases of referrals from other Boards, HSAB will only conduct reviews into cases meeting the statutory SAR criteria. Where these criteria are not met, it will be for the referring LSAB to consider whether or not to carry out a discretionary review of their own.

Discretionary Reviews

The statutory guidance to the Care Act (2014) clarifies that SABs are free to arrange SARs in other situations involving an adult in its area with needs for care and support:

• The SAB needs to weigh up what type of review will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
• Can include cases providing useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
• Can also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.
Cases not meeting SAR criteria may be reviewed by HSAB using other forms of reviews including reflective workshops and partnership reviews.

Appendix D Safeguarding Adult Review Terms of Reference

The Board Manager and the Learning and Review Subgroup 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 adults at risk to inform inter agency and multi-agency practices as they relate to safeguarding adults at risk. 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. Arrangements regarding advocacy support (if appropriate)

10. Strategy for involvement of family members and consideration for signposting to bereavement support.

11. Reference to any parallel investigations

12. Start and completion dates for the Safeguarding Adult Review

13. Key areas to be analysed

14. Strategy for implementation of lessons learnt

15. A strategy for publication of the Overview Report and Executive Summary

16. A strategy for managing media interest.

APPENDIX E 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

APPENDIX F 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 IMR. 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 IMR 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 IMR report writer, the chronology template and the IMR template (which would have already been forwarded to your organisation) which must be used for the compilation of the IMR.

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 IMR 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 IMR 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 IMR 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.

APPENDIX G 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 Review Panel will ask Individual Management Review (IMR) 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 IMR of the decisions, actions taken and services provided to the adult.

The aim of the IMR 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 IMR 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 IMR 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 Adult(s):

DOB/DOD:

Name, agency and contact details of person completing chronology and individual management review (IMR):

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

(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 adults at risk 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 adults at risk 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 adults at risk, 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 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.

APPENDIX H Template for standard letters: Requesting IMR and nominations to the Safeguarding Adults Review Panel

Dear

Re:
Name:
DOB/DOD:
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 Policy. 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 Policy 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 xx, Board Manager.

Yours Sincerely
Chair of the Hampshire Safeguarding Adults Board

APPENDIX I Template - Overview Report

Content of report:

1. Introduction
2. Circumstances leading to a safeguarding adult review being undertaken.
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 review commenced, the commissioning arrangements details of the Independent Chairperson/Independent Overview Report Author.

Terms of Reference
Detail the agreed terms of reference

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 Chronology 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 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
- 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?
- Was there 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 Subgroup will formulate the Safeguarding Adult Review action plan based upon the multi-agency recommendations identified by the Independent Chair/Overview Report author.

Individual Management Review Action Plan Template

Report regarding: …….. (Insert name of service user here)

Action Plan for:…… ……. (Insert name of the agency or organisation)

Produced by…….. (Insert name of the author)

Date: ……

Version: ……

Progress: Red = Not commenced**, A**mber= Progressed, **G**reen= Completed

Rec. No:	**Recommendation** This should be a direct copy of the words used in the recommendation in the IMR or Overview Report	**Action**	**Professional Responsible**	**Intended Outcome**	**Timescale /Target Completion Date**	**Evaluation** How will this action be evaluated? Who will monitor progress? What further action is needed?	**Progress / Date of Completion –** Please do not use 'ongoing'. If outcome not complete add evaluation & mark as Amber	**Progress** Please update the colour to reflect progress.

Guidelines for completing Individual Management Review Action Plans

- Recommendations should be a direct copy of the words used in the recommendation in the IMR or Overview Report.

- In the action column, indicate what action has been taken to address the recommendation or what action will be taken.

- In the outcome 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 timescale column, provide the date action was completed and/or provide a realistic timescale for your agency to address outstanding action.

- In the evaluation column, specify how will this action be evaluated, who will monitor progress and what further action is needed.

- In the progress column, state whether action arising from the recommendation is 'on track' or 'not on track' and update the RAG rating colour to reflect progress. Do not use 'ongoing' – if the outcome is not completed, add an explanatory comment and mark as Amber.

APPENDIX J 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 the adult.

- 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

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 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

Report regarding: ……..... (Insert name of service user here)

Action Plan for:…… ……. (Insert name of the agency or organisation)

Produced by…….. (Insert name of the author)

Date: ……

Version: ……

Progress: Red = Not commenced**, A**mber= Progressed, **G**reen= Completed

Rec. No:	**Recommendation** This should be a direct copy of the words used in the recommendation in the IMR or Overview Report	**Action**	**Professional Responsible**	**Intended Outcome**	**Timescale /Target Completion Date**	**Evaluation** How will this action be evaluated? Who will monitor progress? What further action is needed?	**Progress / Date of Completion –** Please do not use 'ongoing'. If outcome not complete add evaluation & mark as Amber	**Progress** Please update the colour to reflect progress.

Guidelines for completing Safeguarding Adult Review Multi-Agency Action Plans

- Recommendations should be a direct copy of the words used in the recommendation in the IMR or Overview Report.

- In the action column, indicate what action has been taken to address the recommendation or what action will be taken.

- In the outcome 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 timescale column, provide dates actions were completed and/or provide a realistic timescale for your agency to address outstanding action.

- In the evaluation column, specify how will this action be evaluated, who will monitor progress and what further action is needed.

- In the progress column, state whether action arising from the recommendation is 'on track' or 'not on track' and update the RAG rating colour to reflect progress. Do not use 'ongoing' – if the outcome is not completed, add an explanatory comment and mark as Amber.

APPENDIX K Template for standard letters: Letter to agencies

Dear

Re:
Name:
DOB/DOD:
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.

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 agency's involvement.

Yours Sincerely

Chair of the Hampshire Safeguarding Adults Board

APPENDIX L 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 make improvements and reduce the likelihood of 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.

If you feel that you or anyone else concerned feel that you have been affected by what has happened, there are a number of recommended local services are available that can provide you with information as well as bereavement support. A comprehensive directory is available through the following link:

https://www.connecttosupporthampshire.org.uk/directories&Type=Local&Search=bereavement&Page=1

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

APPENDIX M Information for Families about Bereavement Support services available

www.thelossfoundation.org

The Loss Foundation: A charity providing support to people who have lost loved ones to cancer; spouses, family members, friends. The charity operates support groups within London and Oxford, and other supportive events. They also provide an array of bereavement information on their website to support those that fall out of their support group catchment area.

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www.thegoodgrieftrust.org

The Good Grief Trust: enables anyone who has been bereaved to find their nearest local support organisation. Also provides practical help and tips from people who have been bereaved who tell their own stories.

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www.bereavementuk.co.uk

Online support site for those who have been bereaved.

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www.childdeathhelpline.org.uk

Child Death Helpline: 0800 282986

Helpline for anyone affected by the death of a child of any age. Advice, information, listening, befriending, referrals and face to face service by arrangement. Staffed by bereaved parents.

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www.tcf.org.uk

The Compassionate Friends: 0345 123 2304

Helpline and support services run by bereaved parents. Support to parents and their immediate families after the death of a child of any age and from any cause. Local contacts and support meetings, befriending, phone and letter contact, leaflets and publications, postal library, retreats and an annual weekend gathering. Compassionate Friends have a subgroup called Shadow of Suicide for parents and families of children who have taken their own lives.

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www.cruse.org.uk

Cruse Bereavement Care: 0808 808 1677

Helpline offering listening support and practical advice related to bereavement. Puts people in touch with local Cruse branches which can provide individual and group support.

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www.samaritans.org

The Samaritans: 116 123 (free of charge from a landline or mobile).

Provides emotional support. 24hr service.

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www.uk-sobs.org.uk

Survivors of Bereavement by Suicide: National Helpline **0300 111 5065** and other support services run by a self-help group for people bereaved by suicide. Helpline provides listening support and will put people in touch with their nearest local group. Monthly group meetings in various locations. Bereavement pack and literature for survivors. Conferences and support days.

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www.sueryder.org/online-bereavement-support

Sue Ryder Online Bereavement Support makes it easy to connect with the right support from your own home. Whether you're looking for one-to-one professional support, to talk to others in similar situations, or to read expert information resources, you can access support for free on your computer, tablet or smartphone.

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www.rosiecranetrust.org

The Rosie Crane Trust: 24hr helpline **01460 55120** Support to bereaved parents.

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www.samm.org.uk

SAMM (Support After Murder and Manslaughter): 0121 472 2912

Telephone support line for families and friends of homicide victims.

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www.griefencounter.com

Grief Encounter Project: 0808 802 0111

Workshops, one to one counselling telephone advice, resources and an interactive website for bereaved children, young people and their families.

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www.beadproject.org.uk

Bead: Bereaved Through Alcohol and Drugs A source of information and support for anyone bereaved through alcohol or drugs.

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www.childbereavementuk.org

Child Bereavement Charity: 0800 02 888 40

Support for bereaved families, online discussion forums, information.

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www.thelauracentre.org

The Laura Centre: A family bereavement counselling centre which provides confidential counselling and group support free of charge for anyone affected by death of a child, at any age and from any cause. Any school aged child affected by the death of a parent, grandparent or significant adult. Telephone and email support throughout UK, face to face primarily Leicester, Leicestershire, Rutland, Northamptonshire, Derbyshire, Warwickshire and Lincolnshire

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www.the-bereavement-register.org.uk

The Bereavement Register:020 7089 6403 or 0800 082 1230 (24 hour automated registration service)

Service specifically designed to remove from databases and mailing files, the names and addresses of people who have died.

APPENDIX N Template for Standard Letters: Letter to Review Team Representatives

Dear

Re:
Name:
DOB/DOD:
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 which appraises practice and looks at the systems that professionals work within and what can be improved about the system to enable professionals to perform to their best.

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 providing additional data where it is needed and analysis of the review and the team typically includes a representative from each agency involved.

There are one or two Lead Reviewers who are trained in the process and it is their responsibility to support the use of the methodology.

The Review team are also joined by a Case Group who are the group of frontline professionals who were directly involved. there will be a staff briefing to provide an overview of the process as well as much more detailed explanation of the process and methodology, and to allow for any questions.

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

APPENDIX O Template for Standard Letters: Letter to Case Group Representatives

Dear

Re:
Name:
DOB/DOD:
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 "SCIE Systems Learning" methodology which appraises practice and looks at the systems that professionals work within and what can be improved about the system to enable professionals to work to their best.

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 which you are invited to join. 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 one or two Lead Reviewers and a Review Team who are made up of a senior representative of each relevant agency. There will be a staff briefing to provide an overview of the whole process 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

APPENDIX P Guidance for agencies using the SCIE Learning Together 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 appraises practice and evaluates the systems that professionals work within to enable improvements. The evaluation of practice in the individual cases then allows for consideration of a 'window on the system', drawing out wider learning 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 middle or strategic 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. 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 the briefing and two half day meeting throughout the process.

Role of the Lead Reviewers

The Lead Reviewer/s are trained and accredited in systems methodology and are responsible for the facilitation and co-ordination of the review and the production of a Final Report. The Lead Reviewers are responsible for ensuring that each stage in the process is supported and works effectively, including the one day workshop with 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 is the frontline professionals and their immediate line managers who were involved in supporting the adult during the period under review. They are invited to reflect on their practice and contribute. Members of the Case Group may be interviewed as a part of the process of gaining data direct from the front line staff.

Role of SCIE

SCIE provide the training and accreditation of Lead Reviewers. They also support the process of each case review by providing advice in the use of the analytical tools and methodology and offering a supervision session to the lead reviewers.

Appendix Q HSAB Methodologies Menu for Reviews

Safeguarding Adult Review Criteria (Care and Support Statutory Guidance, Section 14) is as follows:

- LSAB must arrange a Safeguarding Adult Review (Statutory 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 adult.

- LSAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support i.e. a discretionary multiagency review, thematic review or single agency review

There is flexibility in what approach and methodology is used, what process is followed and who leads the review of the case. The expectation is that all are published.

The following suggested approaches can be considered when commissioning a review:

- **Level one- Single agency review/ health review**

Individual agency will undertake a review into the case to be agreed/ signed off through existing management procedures. In the case of a health review this will be led by the CCG. Findings from the review will be shared with the Learning and Review Subgroup (LRS). As this option only includes one agency it would not formally come under the banner of a SAR and may not need to be published.

- **Level two – Local Learning Briefing**

If good practice is identified via the LRS from a case review referral received then a local learning briefing will be written. The LRS members will draft and finalise the briefing and once agreed it will be presented to HSAB by the LRS chair or other lead agency as identified. The LRS will also decide whether the briefing is to be published.

- **Level three - Table top workshop**

Practitioners involved in the case are identified by LRS members and attend a half day table top review led by a senior manager, independent of line management of the case. Lead to be identified by LRS. A learning summary is produced as a result of the workshop findings and presented to HSAB.

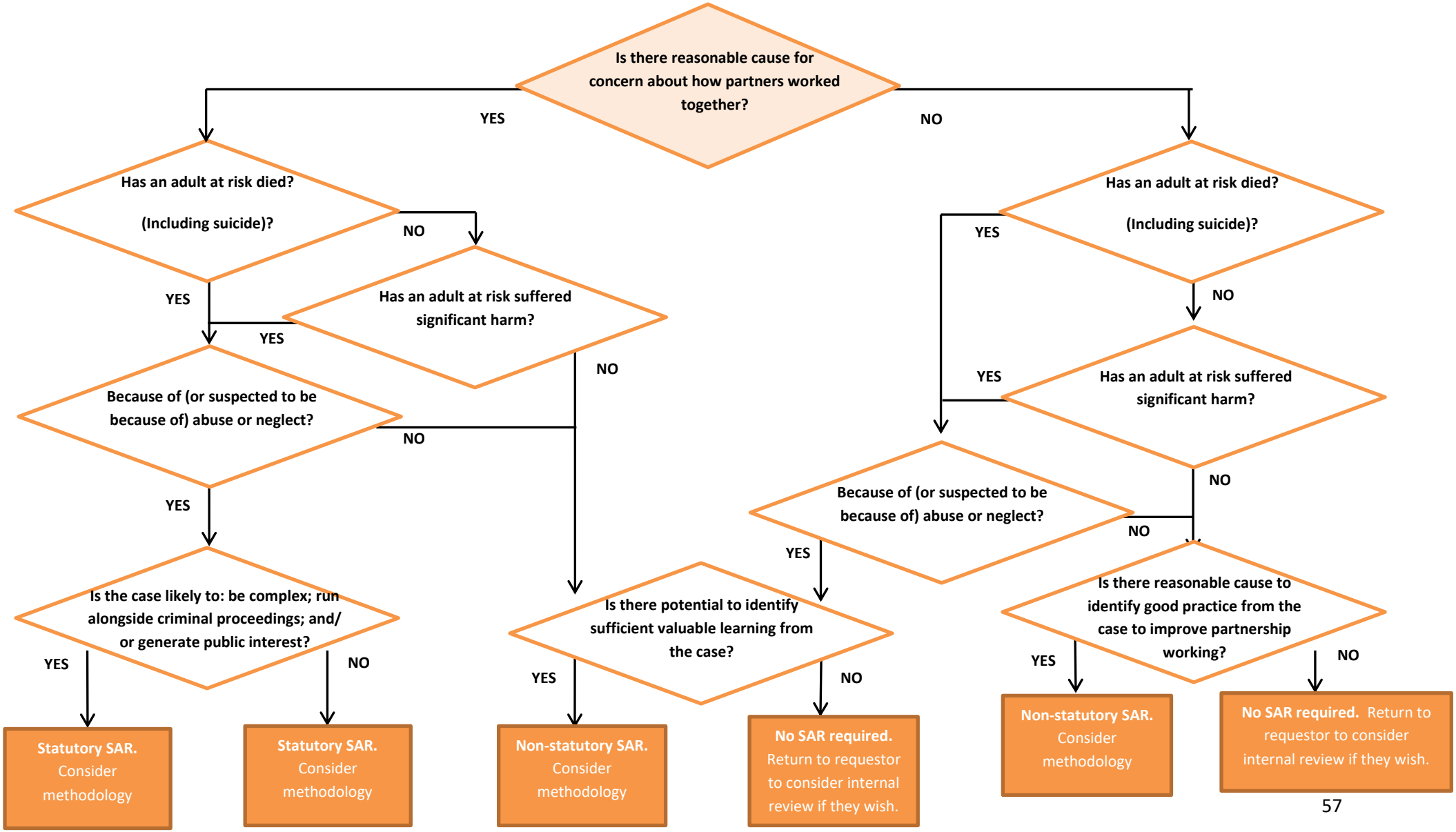
- **Level four – Multiagency partnership review**

This is a more detailed review than level two. As required practitioners may be met individually or as part of a workshop. The Partnership Review will be led by a senior manager from existing agencies or a commissioned independent reviewer. If the review is led by somebody in the partnership they need to be independent of involvement and / or line management staff involved in the case. Lead to be identified by LRS and agreed by HSAB chair. A report is produced and presented to the HSAB ahead of publication.

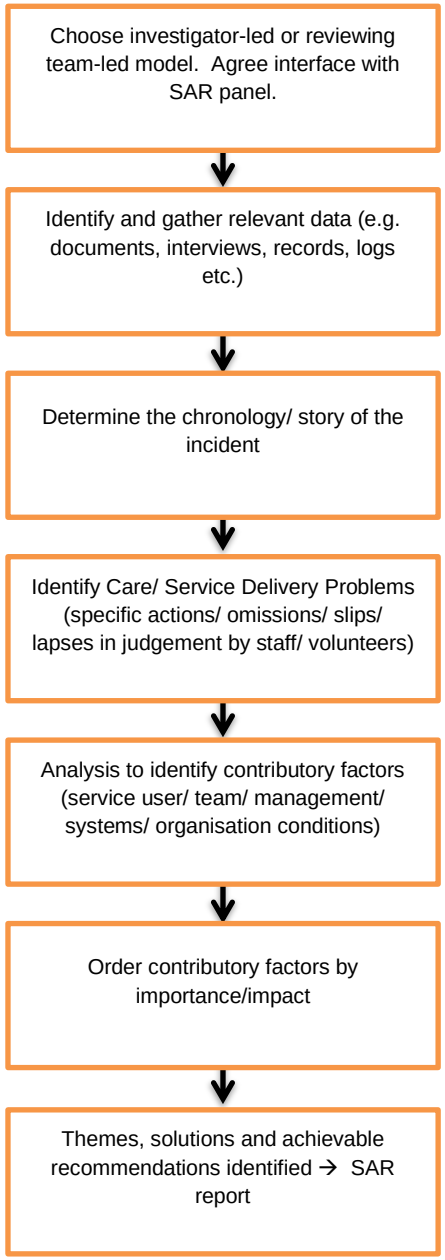
- **Level five – Safeguarding Adult Review**

A statutory SAR will be commissioned where the SAR criteria (as detailed in the care and support guidance) is met. A recommendation by LRS is made for the SAR and agreed by HSAB chair. An independent reviewer will be commissioned to undertake a SAR. A panel will be established consisting of Health, Adult Social Care, Police and any identified specialist agencies as required. Meetings will be held with practitioners as required and a multi-agency workshop held. A final report will be drafted for publication and will be signed off at HSAB prior to publication

Appendix R SAR Methodology Decision Tree



Option A: Systems Analysis



Key features:

- ✓ Team/ investigator led
- ✓ Staff/ adult/ family involved via interviews
- ✓ No single agency management reports
- ✓ Integrated chronology
- ✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
• **Structured process of reflection** • **Reduced burden on individual agencies to produce management reports** • **Analysis from a team of reviewers may provide more balanced view** • **Managed approach to staff involvement may fit well where criminal proceedings are ongoing** • **Enables identification of multiple causes/ contributory factors and multiple causes** • **Range of pre-existing analysis tools available** • **Focusses on areas with greatest potential to cause future incidents** • **Based on thorough academic research and review** • **RCA tried and tested in healthcare and familiar to health sector HSAB members.**	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions • Staff/family involvement limited to contributing data, not to analysis • Potential for data inconsistency/ conflict, with no formal channel for clarification • Unfamiliar process to most HSAB members • Trained reviewers not widely available • Structured process may mean it's not light-touch • RCA may be more suited to single events/incidents and not complex multi-agency issues

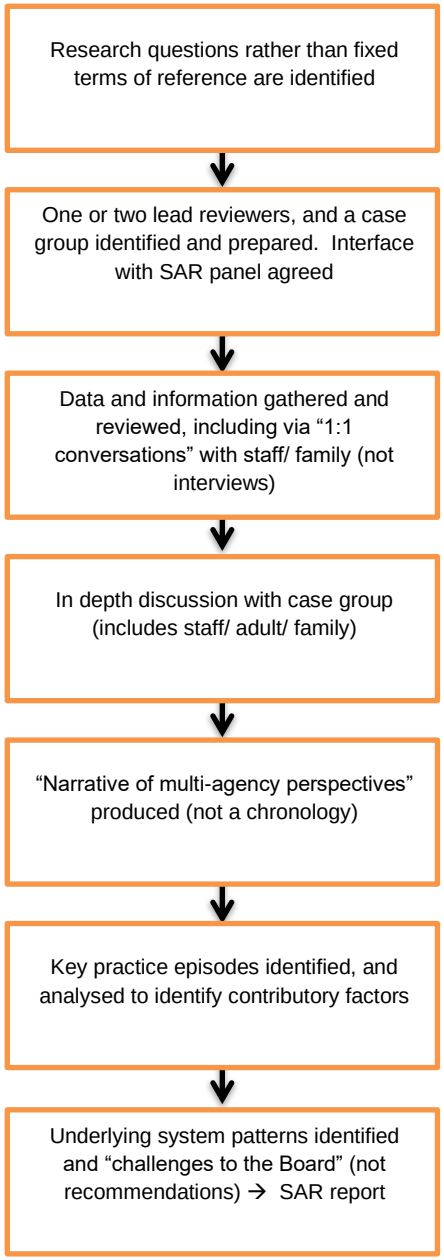
Available models:

Vincent et. al. (2003) Systems analysis of clinical incidents: the London Protocol

Woloshynowych et. al. (2005) Investigation and analysis of critical incidents

NHS National Patient Safety Agency (NPSA) Root Cause Analysis

Option B: Learning Together



Key features:

- ✓ Lead reviewer led, with case group
- ✓ Staff/ adult/ family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; no chronology
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

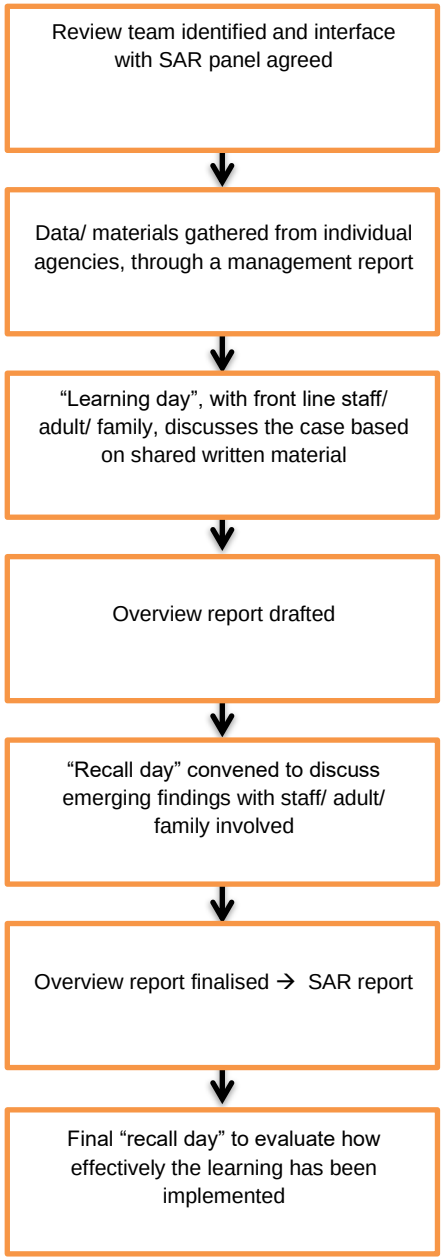
Advantages	Disadvantages

• **Structured process of reflection**
• **Reduced burden on individual agencies to produce management reports**
• **Analysis from a team of reviewers and case group may provide more balanced view**
• **Staff and volunteers participate fully in case group to provide information and test findings**
• **Enables identification of multiple causes/ contributory factors and multiple causes**
• **Tried and tested in children's safeguarding**
• **Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity**
• **Range of pre-existing analysis tools available**
	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
	  • Challenge of managing the process with large numbers of professionals/ family involved
	  • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
	  • Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR
	  • Opportunity costs of professionals spending large amounts of time in meetings
	  • Unfamiliar process to most HSAB members
	  • Structured process may mean it's not light-touch

Available models

SCIE, Learning Together

Option C: Significant Incident Learning Process



Key features:

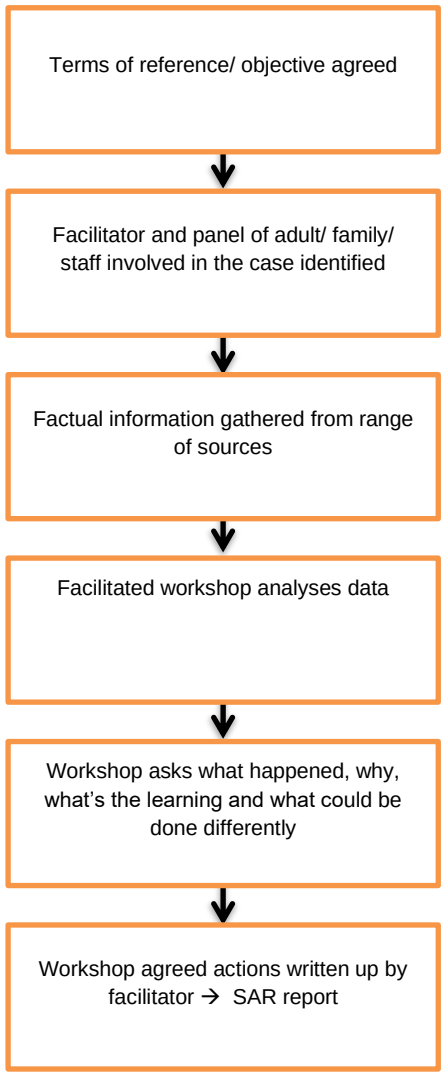
- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

Advantages	Disadvantages
• **Flexible process of reflection – may offer more scope for taking a light-touch approach** • **Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants** • **Has similarities to traditional SAR approach, so more familiar to most HSAB members** • **Agency management reports may better support single agency ownership of learning/ actions**	• Burden on individual agencies to produce management reports • Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR • Opportunity costs of professionals spending large amounts of time in learning days • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses • Not been widely tried or tested, nor gone through thorough academic research/ review

Available models:

Tudor, Significant Incident Learning Process

Option D: Significant Event Analysis



Key features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/ adult/ family involved via panel
- ✓ No chronology
- ✓ No single agency management reports
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourage reflection and change.

Advantages	Disadvantages

• **Light-touch and cost-effective approach**
• **Yields learning quickly**
• **Full contribution of learning from staff involved in the case**
• **Shared ownership of learning**
  ◦ **Reduced burden on individual agencies to produce management reports**
  ◦ **May suit less complex or high-profile cases**
  ◦ **Trained reviewers not required**
  ◦ **Familiar to health colleagues**
	• Not designed to cope with complex cases
	• Lack of independent review team may undermine transparency/ legitimacy
	• Speed of review may reduce opportunities for consideration
	• Not designed to involve the family
	  ◦ Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses

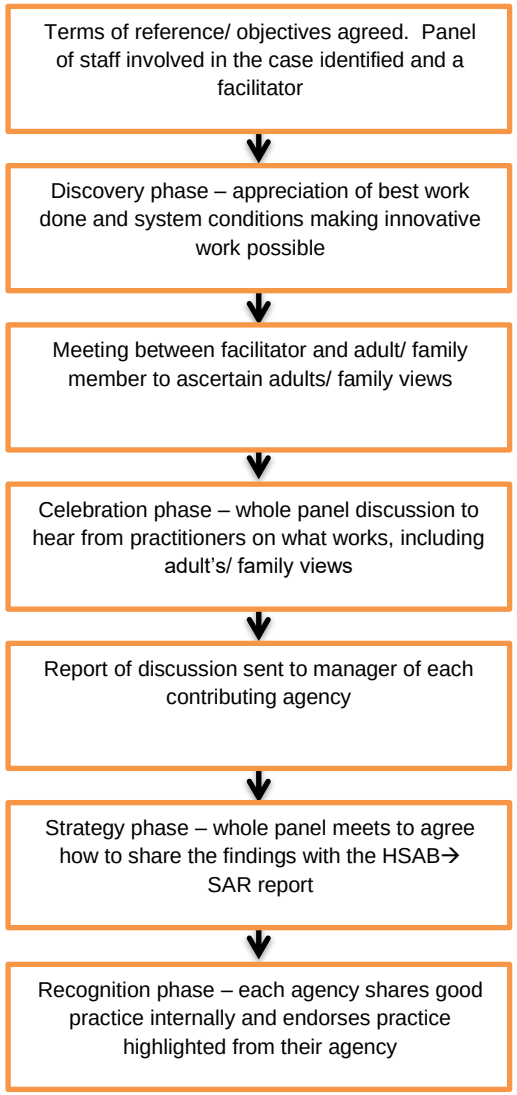
Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis

Care Quality Commission, Significant Event Analysis

Royal College of General Practitioners, Significant Event Audit

Option E: Appreciative Inquiry



Key features:

- ✓ Panel-led, with facilitator
- ✓ Staff involved via panel. Adult/ family involved via meeting
- ✓ No chronology/ management reports
- ✓ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Advantages	Disadvantages
• Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days • Staff who worked on the case are fully involved • Shared ownership of learning • Effective model for good practice cases • Some trained facilitators available • Well-researched and reviewed academic model • Model understood fairly widely	• Not designed to cope with 'poor' practice/ systems 'failure' cases • Adult/ family only involved via a meeting • Speed of review may reduce opportunities for consideration • Model not well developed or tested in safeguarding. Minimal guidance available

Available models:

Julie Barnes, A new model for learning from serious case reviews
Newcastle Safeguarding Children's Board, Appreciative Inquiry Champions Group