warrington
[safeguarding]
adults board

Safeguarding Adult’s Review Procedure

Warrington Safeguarding Adults Board

Warrington Safeguarding Adults Review (SAR) Procedure

1. Introduction

1.1 The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in section 1 of the 2014 Care Act (implemented in April 2015). Safeguarding Adults Board (SABs) are a statutory requirement under the Care Act.

1.2 Warrington SAB oversees and leads adult safeguarding across the locality and has a range of statutory duties that contribute to the prevention of abuse and neglect. This includes the duty to conduct any SARs in accordance with Section 44 of The Care Act. SARs are reviews that examine the way agencies and individuals that have been involved with an adult at risk have acted. The purpose of the SAR is to identify learning that will bring about improvements so that the likelihood of harm to Adults at Risk is minimised.

1.3 This procedure specifies the statutory requirements and the working arrangements of Warrington SAB in respect of SARs.

2. Statutory Duty under Section 44, 2014 Care Act

2.1 There are three broad circumstances under which The Care Act statutory guidance considers a SAR may take place. The guidance makes a distinction between those circumstances where the SAB ***must*** and ***may*** arrange a SAR:

2.2 The SAB ***must*** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

1) 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;

2) EITHER

a) the adult has died, and 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).

OR

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

2.3 A SAB ***may*** also 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). SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

2.4 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

3. SAR Criteria

3.1 The first criterion for determining whether a SAR should be conducted is in establishing whether the adult was in need of care and support services (whether or not the local authority was meeting any of those needs).

3.2 The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014 (the 'Eligibility Regulations'). The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

3.3 In considering whether an adult has eligible needs for care and support, local authorities must consider whether:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes (which are described in the Care Act guidance sections 6.105 to 6.112)
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

3.4 Significant impact is not defined and should be understood to have its everyday meaning.

3.5 The second criterion to be met is establishing a cause for concern about how the SAB, its member organisations, or other persons with relevant functions, worked together to safeguard the adult. A particular emphasis is the extent that they could have worked more effectively to protect the adult from the resultant outcome and therefore the potential for learning.

3.6 The third criterion involves an examination of the link between the death or (other outcome) and suspected abuse or neglect.

3.7 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 as a result of the abuse or neglect.

4. Levels of Safeguarding Adults Review

4.1. From April 2015, Warrington SAB will utilise two levels of SAR

- A level 1 (Statutory) SAR will be required for those circumstances in which the SAB must arrange a SAR.

- A Level 2 (Discretionary) SAR may be conducted in any other situations

4.2 It is to be noted that the review methodology selected will not be pre-determined by the level of the SAR but after consideration of the particular circumstances of each case, with reference to the purpose and principles. In any SAR the approach should be proportionate to the scale and complexity of the issues and the potential for learning.

5. Purpose and Principles of a Safeguarding Adults Review

5.1 The purpose of a SAR is to promote effective learning and improvement action, through identifying what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an investigation.

5.2 The SARs purpose is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

5.3 A SAR should highlight any lessons that can be learned from the case and through a clear set of recommendations; ensure that relevant actions are taken in order to help prevent future deaths or serious harm. This helps to improve both single and inter agency working and better safeguard and promote the wellbeing of Adults at Risk.

5.4 SARs will be undertaken in accordance with the following principles:

- There should be a multi-agency culture of continuous learning and improvement; identifying opportunities to draw on what work and promote good practice

- The approach should be proportionate according to the scale and complexity of the issues and the potential for learning

- SARs should be led by individuals who are independent of the case and of the organisations whose actions are being reviewed, with the skills and experience necessary to maximise learning.

- SARs should be trusted and safe experiences that encourage honesty, transparency and sharing of information. People, who are invited to contribute, should do so without fear of being blamed for actions they took in good faith.

- SARs should be underpinned by a culture of openness, transparency and candour. This should be reflected in the involvement of people affected by the case including the victims of abuse and their families.

- Recommendations and learning will be shared appropriately through local and regional safeguarding networks to ensure that good practice is made available

to those who work closely with adults at risk and those who assist to influence and develop practice in this arena

5.5 The SAB should be primarily concerned with “weighing up” what type of review process best enables this to happen. The level of the review will be determined by the Chair of the SAB following the SAR Screening Panel’s recommendation.

5.6 The findings from SAR’s will be included in the SAB’ s annual report along with relevant service improvements and actions and the reasons for any decisions not to implement actions.

6. SAR Methodology

6.1 The SAB will give consideration to the most appropriate methodology to use as no one model will be appropriate for all cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however it will be determined by and proportionate to the specific circumstances and the scale of the situation.

6.2 Any of the methodologies may be used for any type of case. Methodologies that would usually be considered for the most serious cases include traditional SCR/DHR, action learning and peer review approaches. Other methodologies include but are not confined to a multi-agency practice learning review, a root cause analysis, or a significant event review. There is flexibility in determining the precise process, including variations and combinations of methodology elements on a case by case basis. (See Appendix 1 for additional information on review tools and methodologies).

7. Initiating a Safeguarding Adult’s Review

7.1 Only Warrington Safeguarding Adults Board can commission a Safeguarding Adults Review in Warrington. However any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR.

7.2 Where any individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they may refer a case to the Chair of the Adult Safeguarding Board to establish if there are important lessons for inter-agency work to be learnt from a case. This includes any professional body, members of the public, councillors, MP’s and the coroner. The Secretary of State also has authority under the Local Authority Social Services Act (1970) to cause an enquiry to be held where he/she considers it advisable.

7.3 Warrington SAB member organisations will publicise within their own agencies the criteria and circumstances under which a SAR may be considered and the process under which a referral might be made. This information will also be publically accessible.

7.4 A referral is made by completing the referral form (see appendix 2). Referrals should be made as soon as it is apparent that the criteria may be met, subject to considerations in paragraphs 7.5 and 7.6 below. An unreasonable delay in raising an issue can impact both on the process and the key purpose in a number of ways.

7.5 The SAB will not normally review cases that are more than twelve months old, unless there is significant information that has more recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. This is in order to ensure the optimum effectiveness and learning from the resources employed.

7.6 Prior to making a referral, professionals working with Adults at Risk, should consider the relevant guidance, and discuss with their organisations line manager, designated Adult Safeguarding lead, or SAB representative; or the local authority Safeguarding Strategy Manager, or Head of Service (as appropriate).

7.7 By virtue of the criteria, in cases where a SAR may be indicated, a safeguarding concern and/or enquiry may already have been made. In this case a discussion with the relevant safeguarding strategy manager should normally take place prior to making a referral for a SAR. Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to multi-agency safeguarding policy and procedures which consider any immediate protection required.

7.8 However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have completed suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

7.9 All agencies should have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning, and this protocol is not intended to duplicate or replace these.

8. Decision Making

8.1 On receipt of the SAR referral request, the Chair of the SAB will consider the information provided prior to triggering the next stage of the SAR screening process. The chair may seek further information including clarity about parallel investigations that may be taking place. In some circumstances, the chair of the SAB may decide not to progress further with a referral at this stage and instead recommend further actions. In this case, the reasons for this will be recorded and a response and explanation provided to the referrer. All referrals will be recorded and noted at the SALR sub group.

8.2 After the initial screening process, the Chair of the SAB will request that the chair of the Safeguarding Adult Learning and Review (SALR) subgroup convenes a screening panel at the earliest opportunity. The SALR subgroup is a subgroup of the SAB which helps to make sure that learning and development takes place so that people are safeguarded more effectively.

8.3 The Chair of the SAB will also inform the LA Head of Safeguarding and SAB Manager. This enables appropriate people to be notified and arrangements to be made to support the process. The chair of the SALR in consultation with the LA Head of Safeguarding will confirm the panel membership and the additional information required; the SAB manager and administrator will organise the panel and the LA Head of Safeguarding will oversee the collation of additional information which the panel will need to consider.

8.4 Information requested by the SALR subgroup may be easily provided by agencies (see appendix 3), or it may be appropriate in certain cases, for agencies who are asked to provide information by the SALR subgroup to meet in order to consider, gather or discuss information. The relevant SAB and SARL representatives will be informed of their agencies role and may be required to assist in the coordination of information.

8.5 The SAR screening panel will meet to consider the information in order to make recommendations to the SAB on whether a SAR should or should not be held and on application of the criteria, the level. On conclusion of the meeting, the chair of the SALR subgroup will write to the SAB chair (see appendix 4) with the outcome and the rationale on which it is based (within 24 hours or as soon as is practicable).

8.6 Once the Chair of the SAB has received the recommendation, they will make the final decision about whether a SAR should take place. The SAB chair will then notify the Chair of the SALR and the Local Authority using the appropriate form (appendix 4).

8.7 In the event of the SAB's Chair's decision that a SAR should not take place, the reasons must be recorded and shared with the referrer and the Adult Safeguarding Board. When this is the case and there is a parallel investigation or review process taking place, or if the Chair of the SAB commissions an alternative process, arrangements should be made for the relevant findings to be reported to the SAB via the SARL sub group. The SALR sub group will then ensure that learning can be disseminated and shared across other agencies and where relevant other regional and national networks.

9. The SAR Screening Panel

9.1 The SAR Screening Panel needs to have the information and expertise required to make the recommendation. It will consist of members of the SALR sub group, supplemented with any additional individuals or organisations with the necessary knowledge or expertise pertinent to the circumstances of the case. The SAR Screening Panel may also wish to have available specialist advisers whose role will be to advise it during the process.

9.2 The SAR Screening Panel will be provided with written reports from the key agencies involved. Representatives from agencies may also be asked to attend during the first part of the panel meeting, to help clarify the circumstances of the case. It is important for the panel to have sufficient information before discussion begins. However the panel is not investigating

the circumstances of the incident, and is not conducting the SAR themselves, so the consideration of issues should be proportionate.

9.3 After reviewing all the information available against the criteria and guidance, the SAR Screening Panel will determine if they consider that the criteria for a SAR has or has not been met.

9.4 If it is agreed that the SAR criteria is met, the Panel will recommend what level of review appears to be the most appropriate and proportionate in the circumstances. The SAR Screening Panel may also make recommendations on the review methodology and whether an independent chair and/or author are required. The panel will also consider other issues pertinent to the review such as media, significant other involvement and engagement with the individuals affected.

9.5 If the SAR Screening Panel consider a SAR should not be held, they may recommend that another form of review or investigation is appropriate. This could include a single agency review or a smaller scale audit of agency involvement. This might be the case where for instance there is a safeguarding element and lessons to be learnt regarding the conduct of an agency but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.

10. Commissioning a SAR

10.1 The Care Act guidance states that the Board should aim for completion of a Review within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required.

10.2 On receipt of the SAB Chair's decision to undertake a SAR, the Head of Safeguarding and the Chair of the SALR sub group will liaise in order to make the necessary arrangements.

This will include:

- Notifying the referring agency, SAB members and other interested parties (including CQC and the coroner)
- Setting up a Safeguarding Adults Review Panel (required for all SAR level1 and may be required for SAR level 2, depending on the scale and complexity)
- Identifying appropriately qualified and experienced leads (chair, facilitator and author as required)Identifying and securing the necessary support and budgetary requirements
- Notifying the adult and/or their family as appropriate
- Considering an initial scope and timescales
- Initiating any information requests that are required
- Considering media and communication strategies

10.3 Once the decision has been communicated, each agency will be responsible for taking appropriate actions that may be necessary in relation to the security

of their records. No member agency should comment publicly upon the case without express agreement of both their senior management and the Chair of the SAB.

11. The Safeguarding Adults Review Panel

11.1 In all SARs, there must be clear accountability for implementing and assuring the arrangements, disseminating the learning and implementing agreed actions. In most cases a SAR Panel will be required to undertake and oversee the review and report to the SAB. The SAR Panel should be selected on the basis that they had no immediate line management of the case under review, and should normally include representatives of the three Care Act statutory agencies.

11.2 The panel and the other arrangements should be proportionate to the circumstances of the case and the review methodology. For smaller scale reviews such as a multi agency practice review, a root cause analysis, or a significant event review, then the SARL sub group may be the most appropriate panel. For more complex and high profile situations, the panel will be drawn from a wider group of individuals and organisations with the relevant experience and expertise. For these cases, an independent chair and author may be appropriate. Whether the chair, author and as required facilitator/ reviewer are internally or externally appointed they should have the experience and expertise required; and independence from the case and the actions being reviewed.

11.3 SAR Panel's will set their own meeting schedule and timings appropriate to the case and the methodology; and report this to the SAB. Whilst the frequency and number of meetings may vary, the SAR Panel will need to meet a minimum of 3 times in order to establish, monitor and finalise the review.

Stage 1

11.4 The Panel will have responsibilities from the outset to:

- Specify the terms of reference[1]
- Set timescales, if not already determined
- Confirm the lead roles such as chair, facilitator, reviewer, author and planned methodology
- Link to other interested parties such as the CPS or Coroner
- Coordinate and compile the available information including chronologies and reports of investigations that may have taken place
- Confirm the agencies and the people involved and affected
- Identify, inform and establish links to any other processes ongoing or planned
- Where required, request that Independent Management Reviews are completed
- Identify any additional reports, information or evidence required

[1] The exact requirements will depend on the methodology agreed for the Review; for instance not all methods require IMRs as part of the process.

- Agree the nature and extent of expert or legal advice required
- Develop media and communications plans and with appropriate advice, publishing considerations
- Consider how the adult, advocate and/or family can be involved in the SAR, including any issues relating to Duty of Candour
- Set future Panel meeting dates and times

Stage 2

11.5 During this phase the following functions are likely to be required of the Panel (with flexibility according to the methodology used and proportionate to the circumstances)

- Maintain links with interested parties and parallel investigations
- Produce a comprehensive chronology that covers the critical period collated from all agencies
- Receive and scrutinise additional reports including IMRs and safeguarding/serious incident investigations
- Cross reference information within the reports, identify any omissions or discrepancies
- Conduct/commission any further enquiries
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Identify critical points and actions with any key lines of enquiry
- If the methodology, requires a workshop or learning event, then this will be planned and delivered.
- Develop a framework for the report and consider drafts
- Review progress and timescales and report to the SAB

Stage 3

11.6 During this stage, the members of the SAR panel will discuss and agree the key learning points of the review, the recommendations and actions required; and finalise the report. Some of this work may be able to be undertaken outside of meetings, in which case panel members must commit to prioritise input and feedback to reports that are circulated within timescales.

11.7 On completion, the SAR report will be presented to the SAB, which will:

- Ensure contributing agencies have the opportunity to confirm the accuracy of facts and interpretation of their involvement in the report.
- Confirm the recommendations from the report.
- Confirm action plans, which should be endorsed at senior level by each organisation, and agree accountability
- Confirm to whom the review or parts of the review are to be made available (decisions on publishing will have been taken before completion of the review)
- Commission the dissemination of the review or key findings to interested parties including feedback and debriefing to staff, family members and media

- Confirm the arrangements to ensure that the actions are monitored and updates requested from agencies
- Sign off the action plan when complete

11.8 In Warrington, the SAB will normally exercise its function of oversight of the actions via the SALR subgroup. The SALR subgroup should ensure that identified actions are completed, and any barriers or slippage in achieving outcomes are responded to.

12 Interface with other reviews and investigations

12.1 There are a number of types of review and investigation that may interface with a SAR and it is important to identify any other processes which may be running in parallel or being considered. These include a Child Serious Case Review (SCR), Domestic Homicide Review (DHR), safeguarding and serious incident investigations, criminal justice processes and Coroner inquests. The criteria for a serious incident in the NHS is described in 12.5 below.

12.2 In setting up a SAR, the SAB must consider how the SAR will dovetail with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning; and minimising the impact on those affected by the case.

12.3 Where there are possible grounds for both a SAR and a Child SCR or a DHR then a decision should be made at the outset by the respective decision making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one board leading, with the same or different reports being taken to each commissioning body.

12.4 Any SAR will need to take account of a coroner's enquiry and, or any criminal investigation including disclosure issues, which may impact on timescales. It will be the SAR lead's role – usually the Chair of the SAR Panel to ensure the necessary contacts are maintained with appropriate people.

12.5 Serious Incidents in the NHS include: (Serious Incident Framework NHSE 2015)

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:— the death of the service user; or serious harm;

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare is not taking appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
- This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.
- In the event of the aforementioned occurring the incident would necessitate in completion of serious incident reporting and investigation.

13 Consulting with the Adult at Risk and others affected by the review

13.1 Reflecting the principles of openness, transparency and candour; the SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care act, where an adult has “substantial difficulty” in participating, this should involve representation and support from an independent advocate.

13.2 The SAR Panel needs to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how a known abuser might have some input to the review process.

13.3 Normally, individuals should be notified that the SAR is taking place. Involvement may be by formal notification only, or by inviting them to share their views in a way that suits them.

13.4 The timing of such notification is crucial particularly where there are criminal justice processes running parallel and decisions will need to be taken in consultation with relevant others.

13.5 If a decision is taken to not involve the adult at risk or their family, the reasons should be informed by legal advice and recorded.

13.6 Under the 2014 regulations of the Health and Social Care Act providers are required to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. This ‘duty of candour’ also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

13.7 If an adult affected by a notifiable patient safety incident, has died or experienced serious abuse or neglect (see section 4.3) then a conversation with the family/adult should be considered prior to a referral for a SAR. If a SAR is commissioned subsequently then they should be kept updated on developments from the investigation into the patient safety incident and the SAR.

14. Considerations for Disclosure in an Safeguarding Adults Review

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the ‘right to know’, came into force in January 2005
- Consideration of relevant articles of the European Convention of Human Rights, as incorporated into the Human Rights Act (1998)
- There are ‘absolute’ and ‘qualified’ exemptions under the Act. Where information falls under ‘absolute exemption’, the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a ‘qualified exemption’ or ‘exception’ it must apply the ‘public interest test’
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act (1998) & Children Act (1989) (updated 2004).
- Information sharing between SABs and the Coroner is not defined in statute however case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the SAB has commissioned a SAR information sharing in relation to SAR documents should be considered on a case by case basis. On receipt of a request for documents relating to a SAR, from the Coroner, the SAB will seek legal advice in order to consider Public Interests Immunity arguments.
- Chapter 14 of the Care Act Guidance sets out expectations in relation to information sharing between agencies and SAB’s in relation to SAR’s, including an expectation that information must be shared to enable a SAB to do its job.

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APPENDIX 1: SAR Methodologies and tools

1. Traditional model

This methodology, a traditional model, forms the basis of DHR and SCR in similar fields and historically in adult safeguarding. Typical features include:

- Appointment of a panel, including chair (usually independent) and core membership-which determines terms of reference and oversees process
- Independent report author
- Combined chronology of events (see below)
- Involved agencies produce Individual Management Reports(see below), outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the commissioning board and monitoring implementation across partnerships

Individual Management Reviews (IMR)

IMR's are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes, or individual and organisational practice could be enhanced. They are key learning tools used in several of the SAR methodologies and other similar reviews such as DHRs and SCRs. They can be used in a multi or single agency environment.

It is important that individuals who are asked to undertake IMRs have the relevant skills and sufficient independence from the case being reviewed.

Where it is decided that IMRs are required:

- The SAR Panel should write to the Chief Officer of the organisations involved, providing the template for an IMR (Appendix 5).

- Organisational reports should be prepared by a senior officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learnt and actions taken or to be taken

- In the case of NHS organisations already completing a Serious Incident investigation the information produced such as a report, chronology, findings and an action plan should be transferred to the IMR document, within the scope of the terms of reference agreed

- Individual Management Reviews must be signed off by the Chief Officer of each organisation

Multi Agency Chronology

Chronologies are important tools particularly when combined across organisations. This enables a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment.

Many of the methodologies outlined utilise chronologies within them, however they can be used in isolation to achieve an overview of a case fairly simply, that can assist in assuring or developing multi agency working.

In this approach each agency produces a single chronology of involvement over the period that has been agreed as relevant to the investigation or review. They may also be asked to provide chronologies relating to more than one person of interest in the case.

The chronologies are then combined in a desk top exercise. This enables review by an individual, for example in determining whether there appears to be grounds for further investigation or potential for learning; or where this is the case, more detailed examination and discussion in a multi-agency workshop. This latter process will usually benefit from a facilitator.

Any identified learning points should be noted and translated into actions which are shared with the SAB and implemented.

Advantages and disadvantages of traditional review approach

The relative merits and drawbacks of a traditional methodology are outlined below.

Advantages:

- More familiar to SAB/stakeholders, who may consider it more robust/objective
- Where public/political confidence may only be assuaged via a tried and tested approach
- Where there is multiple abuse or high profile cases/serious incident
- Methodology is likely to be compatible with a Children SCRs/DHR

Disadvantages:

- Can be overly bureaucratic
- Experience of protracted-implementation of lessons learnt/recommendations and may not be sufficiently responsive to time considerations
- Costly-costs may not justify the outcomes
- More likely to be perceived as attributing blame
- Frontline staff often precluded, so disengagement from process and subsequent learning

2. **Action learning approach:**

This option is characterised by reflective/action learning approaches, which identify both areas of good practice and those for improvement and do not apportion blame. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers, agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to SAB, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the SAB

Further variance

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documents review, staff interviews and report production.

The table below is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the Safeguarding Adults Board in consideration of the best fit and individual preferences in the light of the case in question.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Health and Social Care Advisory Service (HASCAS)
- Paul Tudor-Significant Incident Learning Process
- Social Care Institute for Excellence (SCIE) - Learning Together Model

Although embodying slight variations all of the above models are underpinned by action learning principles.

Advantages and disadvantages of action learning review approach are outlined below

The relative merits and drawbacks of this review approach are outlined below:

Advantages:

- Significant evidence approach is much more efficient
- Swiftness of conclusion and embedding the learning

Action learning approach enhances:

- Partnership working
- Mutual recognition of alternative partner perspectives
- Collaborative problem solving
- Involvement of both frontline staff/senior managers secures both strategic and operational perspectives.
- Unique perspective of staff involved in the case, reflective of the systems operating at the time
- Approach allows for identification of system strengths/positive practice
- Learning take place through the process and there is enhanced commitment to its dissemination

Disadvantages:

- Methodology less familiar to many

3. Peer review approach

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this SAR option regarding the balance of peer team to maximise identified expertise and increase viability. They can be developed as part of regional reciprocal arrangements which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning. Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the SAR.

The appointed peer team/panel should agree the Terms of Reference and specific methodology with the SAB.

Advantages and disadvantages of peer review approach

The relative merits and drawbacks of this review approach are outlined below.

Advantages:

- Objective - independent perspective to particular case/aspects of safeguarding practice
- Usually via trusted sources sharing common experiences/understanding
- Can be part of reciprocal arrangements across/between partnership
- Very cost effective, usually no fees incurred

Disadvantages:

- Capacity issues within partner agencies may restrict
- Availability
- Responsiveness
- Where political or high profile cases deems local oversight is preferable

4. Multi agency practice learning review

This approach is suitable where several organisations have been involved in a case and it has been determined that there is the potential for learning and/or a need to refine or introduce policies and procedures to improve how they can work together in the future, to minimise a repeat of the incident concerned.

The methodology should be proportionate to the incident, however would normally involve the compilation of a multi agency chronology, which is used to highlight critical areas for further examination within a facilitated workshop. The review should make best use of all available evidence including any single agency investigation reports and /or safeguarding investigations in order to maximise learning and reduce administrative burden. Normally a suitably qualified chair from one of the SAB member organisations would lead and facilitate the review and a report author commissioned from within the SAB partners, who is suitably independent to the case produce a summary report and action plan.

Key priorities are ensuring the participation of all organisations in the coordination of information, participation in the workshop and in implementing the action plan.

5. Root Cause Analysis (RCA)

RCA is a technique which can be used to uncover the underlying causes of an incident. It looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events working back from the incident itself and identifies a range of factors which contributed to the incident.

This allows the real causes and contributory factors to be identified so that the relevant organisations can learn and put remedial actions in place.

6. Significant Event Analysis (SEA)

This method brings together managers and/or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently. Its focus is on learning which can lead to future improvements and it results in an action plan with recommendations for learning and development. Staff are brought together in a facilitated team approach.

This methodology has been used for many years in General Practice and in other areas of the NHS. The Adult at Risk is not involved in SEAs, however the findings may instigate further review or investigation which should involve them.

Appendix 2: Referral to the Warrington Safeguarding Adults Board

Any agency or individual can refer a case for consideration by the Warrington Safeguarding Adults Board. This form can be used to refer a case that may meet the criteria for a Safeguarding Adult Review or a case where there are significant and unresolved concerns and the decision making framework for a SAR may be appropriate.

Prior to making a referral to the SAB the referrer must consider the needs for care and support of the adult who is the subject of the referral, as set out in section 3 of the Multi Agency Safeguarding Adult Review Guidance.

Any referral made or information supplied should be done so in accordance with the relevant legislation, policy and procedure guidance and wherever possible, reference to the SAB multi agency procedures and Safeguarding Adult Review guidance.

Warrington Safeguarding Adult Board SAR Referral form

Details of Referrer	
Name:	
Job Title (if professional referral)	
Organisation (if professional referral)	
Contact Details (include telephone number and e mail)	
Address:	
Relationship to the adult at risk:	
Date referral submitted:	
Details of adult at risk	
Name:	
Address:	
Date of birth:	
Date of death (if applicable)	

Cause of death (if known)	
Ethnicity:	
Name and address of GP:	
Details of significant others (include legally recognised next of kin where this is known, family members, carers, advocate, representative)	
Please list any agencies that the person is or has been involved with to your knowledge (for example adults social care, housing, police, voluntary bodies and so on)	
Please provide the details of who you have discussed this referral with including:	
Name	
Position	

Organisation	
Relationship to you	
Date of discussion	
Outcome	
Please include any discussion you may have had with the person subject to this referral (if applicable) or with their significant other(s)	
In addition please provide the following details	
Brief summary of any evidence/concerns you have about the adult being at risk of abuse and neglect	
Please provide a summary of why you are referring this case for consideration by the Safeguarding Adults Board (please include a brief description of the incident(s) and the impact on the adult at risk, as well as any concerns about the way agencies have worked together)	

Please provide details of any other investigations you are aware of concerning the case (For example serious incidents, criminal, health and safety and safeguarding). **Name and contact details of the Safeguarding Strategy Manager or lead person in any other investigation.**
If the adult at risk is subject to an ongoing safeguarding investigation, please provide additional details (if known) as follows: **Details of the initial alert**
Subsequent developments including risk management plans
Please provide any additional details that may be useful for this referral:

Please forward this form to WSAB Manager - wsab@warrington.gcsx.gov.uk

You may also post this form to:
Warrington Safeguarding Adult Board,
Safeguarding and Quality Assurance, 1st Floor New Town House,
Buttermarket Street,
Warrington,
WA1 2AH

Please mark it Private and Confidential for the addressee only. Please note that this form contains personal information and should only be submitted by secure means.

For Completion by the SAB Manager
Date referral received: Date discussed with the SAB chair: Details of outcome to referrer include date:

APPENDIX 3: Information for SAR's and SAR screening

warrington [safeguarding] adults board

Name of Organisation	

Name & job title of Manager Completing Report	

Date of Report	

ADULTS DETAILS	

Surname	
First Name	
Any Alias's	
Sex	
D.O.B	
Home Address	
	Post Code:
GP Details	

Date of Death and/or Serious Harm	

Ethnic Group	☐ White ☐ Mixed ☐ Asian or Asian British ☐ Black or Black British ☐ Chinese or other ethnic group ☐ Not known/not stated

OTHER HOUSEHOLD MEMBERS AT FAMILY ADDRESS		
Name	D.O.B	Relationship to Adult

OTHER SIGNIFICANT PEOPLE		
Name	**D.O.B**	**Relationship to Adult**

DATE OF FIRST CONTACT; DATE OF LAST CONTACT BY YOUR ORGANISATION		
Date	**Circumstance**	**Seen By**

Description of involvement – how & why you have had contact with the individual/s

Other agencies involved – list any that your organisation is aware of

Details of any internal investigations your organisation has already started or completed (please mark N/A if none have been commenced or completed)

<u>Chronology Guidance</u> Before completing your chronology please consider the Care & Support Needs of the adult involved and the impact of these on their wellbeing. Simply tick those elements that you think apply. By completing this you will assist the panel to understand why you believe the individual is an "adult at risk" and in what ways.	
Any known care and support needs	**Please '✓'**
Managing and maintaining nutrition	
Maintaining personal hygiene	
Managing toilet needs	
Being appropriately clothed	
Being able to make use of the home safely	

Maintaining a habitable home environment	
Developing and maintaining family or other personal relationships	
Accessing and engaging in work, training, education or volunteering	
Making use of necessary facilities or services in the local community including public transport and recreational facilities or services	
Carrying out any caring responsibilities the adult has for a child	

Areas where there is or is likely to be a significant impact on the adult's wellbeing	**Please '✓'**
Personal dignity	
Physical and mental health and emotional wellbeing	
Protection from abuse and neglect	
Control by the individual over day-to-day life	
Participation in work, education, training or recreation	
Social and economic wellbeing	
Domestic, family and personal relationships	
Suitability of living accommodation	
The individual's contribution to society	

CHRONOLOGY OF ORGANISATION INVOLVEMENT

Construct a comprehensive chronology of relevant involvement by your agency over the period of time set out below, using the template on the following page.

- **State when the individual was seen including any history known that you feel is relevant to events**
- **Consider the events that occurred, the decisions made and the actions taken or not**
- **Identify within events whether practice fits with your organisations policies and procedures or where relevant national guidance**

Timescale for the chronology: [to be identified by SAB Manager at time of distribution]

PLEASE NOTE THIS DOCUMENT MUST BE RETURNED IN ITS CURRENT FORMAT.
IT IS NOT ACCEPTABLE TO AMEND THE DOCUMENT IN ANYWAY.
ALL AGENCIES ARE REQUIRED TO RETURN INFORMATION IN THE SAME FORMAT TO ALLOW FOR MULTI-AGENCY CHRONOLOGY DEVELOPMENT FOR PANEL REVIEW.

Please detail below a chronology of involvement:

Date **e.g. 2/3/16 – do not use '.'**	**Time** **e.g. 24 hr format**	**Source** **e.g. case file, witness interview etc.**	**Event** **e.g. summary of the event & relevant observations. Provide rationale for actions taken/not taken and if known outcomes**	**Positive Practice** **e.g. in-line with organisations policies and procedures or national guidance**	**Unexpected practice** **e.g. deviation from expected processes, policies or procedures not supported by guidance**
14/03/16	14:00	Witness interview	Ms A attended 30 minutes late for a budget support meeting and due to other appointments Worker B could only offer 15 minutes. Worker B provided Ms A with a template to start to identify debts which could be looked at in the next meeting and offered a further appointment for later that week. Worker B advised Ms A that if she would find it difficult to use the template between meetings and would rather fill it in together she could leave it behind and return to it later. Ms A appeared to accept the offer of help and agreed to return later that week with the template partially filled in.	Worker made space to ensure there were no urgent issues despite the client being late. As per organisation procedure a template was given to start debt review process. A further appointment within 5 working days was offered and arranged.	It is usual for templates to only be issued once literacy issues have been reviewed but this was not possible in the time given. On review it is possible the template should not have been given at this brief initial appointment.

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APPENDIX 4: Panel Chairs Decision Form

SAFEGUARDING ADULT LEARNING AND REVIEW CRITERIA PANEL held on

RECOMMENDATIONS TO WARRINGTON SAFEGUARDING ADULTS BOARD CHAIR

Name of Adult: ______________________________ **DOB:** ________________

Recommendations from the SALR Panel: **(To include any additional recommendations from SALR Panel: including consideration of the need for an independent author and/or chair, timescales, family/relevant person contact and representation or involvement, agencies to be involved, communications and media elements) To also include any contrary of dissenting views.**
Reason for recommendations to include type of review if level 1 SAR not recommended:
Comments/confirmation from WSAB chair:

Date____

APPENDIX 4a: Agenda and Guidance Notes for Chair of SAR Criteria Panel

1. Introductions

Ensure that SAR criteria panel has appropriate representation and that all present introduce themselves by name, organisation and position

The panel will have been established on a bespoke basis to ensure it has the expertise required to make the recommendation. It will comprise of the SALR sub group and any additional members who have been identified as necessary. It should comprise of representatives from the three statutory agencies including representatives of Warrington Borough Council, Police and Clinical Commissioning Group.

The SALR sub group may also have sought representation from other individuals or organisations with the relevant knowledge or expertise in order to advise the panel.

2. Purpose of Meeting

The chair will set out the primary purpose of the meeting as follows:

- The panel, after reviewing all the information available against the relevant guidance, will determine if they consider that the criteria for a SAR has or has not been met
- The panel chair will record the rationale for the decision, including any contrary of dissenting views of panel members
- The recommendations will be communicated with the chair of the WSAB using the form at Appendix 2
- If the panel believe the criteria is met, they will recommend what level of review appears to be the most appropriate and proportionate in the circumstances
- The panel will also consider issues pertinent to the review such as media, significant other involvement and where appropriate specifics of a review as set out in Appendix 2.
- The panel chair will set out expectations of information sharing along with confidentiality requirements

3. Information

The panel chair will establish basic details in relation to the individual in this case including the persons:

- Name
- Date of Birth
- Ethnicity
- Address
- Details of significant others/family members/carers

The starting point will usually be with the Police for any details of events, including cause of death or nature of serious injury.

The panel chair should ensure that all relevant agencies have completed a written report (available for the meeting and e mailed electronically to the SAB Manager or other delegated individual)

It is important for the panel to hear sufficient information in order to allow proper reflection before discussion begins to take place as to whether a SAR is required. The panel is not investigating the circumstances of the incident, and is not conducting the SAR themselves, so it is important that consideration of issues should be proportionate in order to make a decision as to whether to recommend a SAR to the chair of the SAB.

The panel chair should request that agencies do not cover information already covered by another organisation.

The chair should also ensure that panel members (but not agency representatives) have the opportunity to ask any supplementary questions, within the remit of the panel's role.

The chair will ask agency representatives to leave the meeting once the panel are satisfied that they have no further questions. At this point the panel should begin their discussions.

4. Panel Discussion

The panel should return to the criteria outlined in appendix 1.

- The panel chair will ask each panel member to consider if the criteria for a SAR level 1 has been met and the reasons for the decision if the criteria has been met or not
- The panel chair will ask each panel member to consider if the criteria for a SAR level 2 has been met and the reasons for the decision if the criteria has been met or not
- If the consensus view of the panel is that the criteria for a SAR 1 or 2 has not been met, it may consider whether a single agency review may be appropriate in the circumstances, the outcome of which may be reported back to the SAB
- Based on the consensus of the panel's opinion, the chair will record the outcome on the letter to the SAB chair

5. Actions from the Panel Meeting

- The panel chair should advise the SAB chair in writing of the recommendations of the panel (pro forma appendix 2) within 24 hours, or as soon as practicable
- The SAB chair will record their decision onto the pro-forma (appendix 2)
- SAB chair confirms the panel's decision via the pro-forma to SAB Manager
- The SAB Manager notifies the SAB chairs decision to the panel members
- SAB Manager informs any relevant agencies of the decision (CQC for example)
- Minutes of SAR panel to be formally signed off by the chair of the panel