Dorset Safeguarding Adults Board and Bournemouth & Poole Safeguarding Adults Board

Safeguarding Adults Review

Policy

30 May 2015

Bournemouth and Poole Safeguarding Adults Board
and
Dorset Safeguarding Adults Board

Safeguarding Adults Review Policy

Appendices

1. INTRODUCTION

The purpose of this document is:

- To ensure that local practice is in line with:
    - Current legislation – The Care Act 2014
    - Best practice nationally
- To support the view that the public interest is best served by the presence of an effective Safeguarding Adults Review process;

2. BACKGROUND

Relevant Standards and Guidance: Safeguarding Adults Reviews

The Care Act 2014 sets out a clear framework about how local authorities and other parts of the health and care system should protect adults at risk of abuse or harm. This includes a duty to conduct Safeguarding Adult Reviews in specific circumstances.

Safeguarding Adult Boards must arrange a Safeguarding Adult Review 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.

Safeguarding Adults Boards must also arrange a Safeguarding Adults Review if an adult in its area has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect. In the context of Safeguarding Adults Reviews, 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. Safeguarding Adult Boards are free to arrange for a Safeguarding Adults Review in any other situations involving an adult in its area with needs for care and support.

The two paragraphs above are taken from the Care and Support Statutory Guidance and are not prescriptive but open to local requirements. The adult must have needs for care and support, but does not have to have been in receipt of care and support services for a Safeguarding Adult Review to be considered.

Therefore it is for each panel to consider each case on its merits and decide on appropriate, proportionate action.

3. PURPOSE OF SAFEGUARDING ADULTS REVIEW (Learning not blaming)

The purpose of holding a Safeguarding Adults Review is not to reinvestigate or to apportion blame; it is concerned with preventing future deaths/serious harm occurring again.

Safeguarding Adults Reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and applied to future cases to prevent similar harm from occurring again.

The purpose of a Safeguarding Adult Review is not to hold any individual or organisation to account – other processes exist for that purpose which include each partner organisations own disciplinary procedures – but to focus on the learning and Appendix 7 gives some suggestions as to how this might be achieved.

This learning needs to be shared and the statutory Duty of Candour places a requirement on providers of health and adult social care to be open with people and their families when there are failings or things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

4. CRITERIA FOR SAFEGUARDING ADULTS REVIEW

The Safeguarding Adults Board has the lead responsibility for conducting a Safeguarding Adult Review.

As stated above, Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect or has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect.

Examples may include:

- An adult at risk has sustained a potentially life-threatening injury through abuse or neglect, suffered serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard adults in vulnerable situations.
- Serious abuse takes place in an institution or when multiple abusers are involved. In these circumstances the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.
- Financial, institutional or systemic abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a person's well-being and it is of a nature where there are serious negative outcomes for the individuals concerned.

- Any other circumstances, which the Chair of the relevant Safeguarding Adults Board agrees, should be the subject of a Safeguarding Adults Review.

The paragraphs above show that the criteria for carrying out a Safeguarding Adult Review is broad and therefore the approach taken should be proportionate according to the scale and level of complexity of issues being examined. Safeguarding Adults Reviews triggered by the death or serious injury of an adult involving abuse or neglect are reactive. Safeguarding Adults Reviews can with the broader, less prescriptive definition be proactive and pre-emptively tackle practice issues before an incident of harm occurs for example:

- Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults;

- To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

5. LEARNING THAT THE SAFEGUARDING ADULT REVIEW NEEDS TO ACCOMPLISH

In any Safeguarding Adults Review a there is a need to achieve an understanding of:

- What happened;

- Any errors or problematic practice and/or what could have been done differently;

- Why those errors or problematic practice occurred and/or why things weren't done differently;

- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become recommendations for learning;

- What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases.

A quality assurance process should aim to build on rather than duplicate the work already completed in the course of a review and should understand the analytic techniques and tools used in the particular model being used and the content of any supervision provided as part of that model.

6. TOOLKIT (SAFEGUARDING ADULTS REVIEWS)

A range of tools can be used to undertake the necessary investigations that make up a Safeguarding Adults Review.

No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding and remedial action. Sometimes it will also help family and friends understand what happened, but this is not the primary function of a Safeguarding Adults Review and must not replace the requirement for individual agencies to respond to concerns and complaints.

The Safeguarding Adults Board should primarily be concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. Safeguarding Adults Reviews may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

The following principles should be applied by Safeguarding Adults Boards and their partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- Reviews of cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed (not necessarily an independent overview author);

- Relevant professionals should be involved fully in reviews and invited to contribute their perspectives;

- Where possible adults at risk are to be involved in a Safeguarding Adult Review about their experience. If they have any significant difficulty in being involved an advocate may help them to be as involved as far as possible in the process.

- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

  Therefore choice of Safeguarding Adults Review tool used should be dependent on the details of each case and:

- Justified and in line with this policy;

- Give a proportionate response that is fit for purpose;

- Promote an open and reflective learning culture.

The options for conducting a Safeguarding Adult Review are detailed in the appendices. However in all cases at least one reviewer is required and in order for the review to be effective the skills and experience expected of those undertaking a Safeguarding Adult Review need to include:

- Strong leadership and ability to motivate others;

- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;

- Collaborative problem solving experience and knowledge of participative approaches;

- Good analytical skills and ability to manage qualitative data (often specialist training is required);

- Safeguarding knowledge;

- Inclination to promote an open, reflective learning culture

The Guidance requires the reviewer/s to be independent of the case (and the organisation) under review but not necessarily an external consultant so salaried professionals in the local safeguarding network (but not involved in the case) may be appropriate staff for the team.

In Bournemouth, Poole and Dorset the Safeguarding Adults Review panel has a subgroup, which reports into the panel called the 'Safeguarding Leads Group'. Part of this groups remit is to look into cases that do not require a comprehensive Safeguarding Adults Review but where it is thought there is learning to be derived could include proactive or reactive reviews.

The Safeguarding Adults Review panel can create a second time-limited group to consider specific cases that require a proportionate review. These are the two forums that currently could be used for investigating Safeguarding Adult Reviews. The possible tools for carrying out a Safeguarding Adults Review are detailed in the Appendices and listed below (Tools for conducting a review).

Tools for conducting a review: Independent lead reviewer chronology (Appendix 3)

Currently the Bournemouth, Poole and Dorset Boards have a methodology for carrying out the old-style Serious Case Review that includes a chronology of events and Independent Author.

Tools for conducting a review: SCIE lead reviewer model (Appendix 4)

Learning Together supports learning and improvement in safeguarding adults and children using systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture.

Tools for conducting a review: Hybrid version developed by the Children's Boards locally - Bournemouth, Poole and Dorset (Appendix 5)

This tool developed locally, takes from the systems methodology used in SCIE and the more traditional chronology of events. It has been used successfully locally.

Choosing the most appropriate tool

Depending on the case (and each case will be considered individually on its merits) the Safeguarding Adults Review panel will directly make a decision with regards which methodology would be most appropriate given the case under consideration.

No one model is prescribed, rather a toolkit of options is available. How a review is conducted will inevitably affect the learning gained. Some analytical techniques ('tools') from the toolbox of approaches are potentially helpful at various stages of the review. It is envisaged that over time in-house expertise is built up to identify the most appropriate tool.

7. TIMESCALES

Reviews will aim be completed within 6 months – if this is not possible then a full explanation should be given in the annual report.

8. JOINT REVIEWS

Where there are possible grounds for a Safeguarding Adults Review and a Domestic Violence Homicide Review or Safeguarding Children Serious Case Review, Multi Agency Public Protection Review, Mental Health Service Review and/or other such formal review processes, then a decision should be made at the outset by the decision makers involved as to which process is to lead, who is to take which role, and who is to chair with a final joint report being taken to the necessary commissioning bodies. Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for organisations involved.

Similarly Health carry out Serious Incidents Requiring Investigation (SIRI) and any relevant investigation should be shared with the Safeguarding Adults Review panel so that resources and information are made best use of.

In setting up a Safeguarding Adults Review the Safeguarding Adults Board should also consider how the process could dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Review or Domestic Homicide Review, a criminal investigation or an inquest.

Any Safeguarding Adults Review will need to take account of a coroner's inquiry, and or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

A coroner is legally entitled to require information provided to Safeguarding Adults Reviews as well as the overview report itself.

9. PROCESS FOR INITIATING A SAFEGUARDING ADULTS REVIEW, APPEALS AND COMPLAINTS

The panel acts as an advisory group to the Chair who is responsible for making the decision about whether to proceed with a review or not.

The Safeguarding Adults Board commissions any Safeguarding Adults Reviews.

Applications must be made in writing to the Chair of the Safeguarding Adults Board, who will decide, in consultation with the Safeguarding Adults Review Panel members, if a review should be carried out. All Board members will be informed when a Safeguarding Adult Review is taking place (see Appendix 6 for relevant forms)

The Local Government Ombudsman has jurisdiction to investigate complaints about safeguarding investigations for which the Councils have coordinating responsibility. Although safeguarding investigations are multiagency in nature this does not preclude the Local Government Ombudsman from investigating matters that relate to the actions of professionals employed by organisations that do not fall within the Local Government Ombudsman's jurisdiction.

Depending on the nature of the complaint the current Local Government Ombudsman practice, when receiving a complaint is to consider whether:

- The safeguarding investigation is proportionate
- The Council has taken appropriate action in response to the findings of the safeguarding investigation
- The Council continues to monitor the situation
- The Council can provide evidence why the safeguarding allegations did not meet the safeguarding threshold
- There were any delays or other failures in the process
- Whether the conclusions are consistent with the evidence
- The Council considered all relevant and available evidence

Appeals

The decision about whether to undertake a Safeguarding Adults Review should be made within 6 weeks from receipt of the initial request. In the event of an application being turned down, the reasons need to be recorded in writing by the Chair and shared with the applicant. If the initiator wants to appeal against a decision not to carry out a Safeguarding Adults Review it should be put in writing to the Independent Chair of the relevant Safeguarding Adults Board. The decision will be reviewed from a Director of Adult Social Care of one of the three Local Authorities party to the Safeguarding Adults Review Panel who is not connected to the case. Should an appeal be made about a case that involves all three Local Authorities the review of the decision will be conducted by the Independent Chair of the Local Safeguarding Children's Board (local to the case).

Complaints

The complaints procedure of the lead local authority or other relevant partner organisation, depending on the nature of the complaint of the case in question should be followed should a complaint be made.

10. ANNUAL REPORT and REPORTING

All Safeguarding Adults Reviews conducted within the year must be referenced within the annual report together with relevant service improvements planned, with timescales, and achievements. The Safeguarding Adults Board must include the findings from any Safeguarding Adults Review in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where the Safeguarding Adults Board decides not to implement an action then it **must** state the reason for that decision in the Annual Report.

Safeguarding Adults Review reports should:

- Provide a sound analysis of what has happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- Be written in plain English
- Contain findings and recommendations of practical value to organisations and professionals
- Be suitable for publication
- Be translated into a SMART action plan that can be effectively monitored (by the subgroup) with clear outcomes.

11. ADDITIONAL CONSIDERATIONS FOR A SAFEGUARDING ADULTS REVIEW

- There will be a need to address the budgetary requirements for undertaking a Safeguarding Adults Review, which will be the responsibility of the relevant Safeguarding Adult Board.

- Safeguarding Adults Reviews should reflect the six safeguarding principles, (empowerment, prevention, proportionality, protection, partnership and accountability) Safeguarding Adults Boards should agree Terms of Reference for any Safeguarding Adults Reviews they arrange and these should be published and openly available.

- Due regard for criminal/civil process should be observed at all times.

- Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate.

- Agencies should adhere to the Pan Dorset Overarching information Sharing agreement and Boards Personal Data Exchange Agreement.

- Relevant legislation for example the Care Act 2014 Children Act 1989, Children Act 2004, Mental Capacity Act 2005 and Care Act 2014 must be adhered to.

- There may be need for the completion and implementation of media and communication strategies.

12. TERMS OF REFERENCE FOR A SAFEGUARDING ADULTS REVIEW

The terms of reference for a Safeguarding Adult Review are listed in Appendix 1.

The terms of reference for a Safeguarding Adult Review panel are in Appendix 2.

13. THE PROCESS

If a request is made for a Safeguarding Adults Review to take place (either a reactive review or a proactive review; a proactive review perhaps taking data from audit/complaints) then the following steps should take place:

- Request goes on the agenda for the Safeguarding Adults Review subgroup of the Boards;

- Subgroup decides if a Safeguarding Adults Review should take place, however it is the Safeguarding Adult Board's chair who also chairs the safeguarding adult review subgroup, who decides if a safeguarding Adult Review should take place taking into account the views of the subgroup. The chair will also consider:

    - Methodology to be used

    - Risks

    - Level of review – proportionality is critical (eg complexity of review – full, medium, low)

    - Recruit a panel and Chair for the review – set timescales (that fit with any criminal proceedings via CPIA that may be being carried out) and methodology including timescales for chronology if appropriate

- Panel to report back to subgroup on progress and with final report, recommendations and SMART action plan with achievable outcome targets

Clearly there are benefits to building up an internal expertise within the Board partnership organisations of carrying out Safeguarding Adult Reviews. Links with the Children's Boards could be explored to share resources and perhaps work reciprocally to retain some independence. A register of candidates for panel membership could be explored. This would keep the expertise local and costs low.

Potential panel (time limited Task and Finish group for each case) members may include:

Independent Chair
Any members of the safeguarding leads group
Any members of the Board
Any members of the Safeguarding Adults Review subgroup
Partnership Officer – Dorset
Business Manager – Bournemouth and Poole

14. ACTION PLANS AND RECOMMENDATIONS FOLLOWING A SAFEGUARDING ADULTS REVIEW

Action plans resulting from a Safeguarding Adult Review need to be SMART with robust outcomes that can be monitored and measured. They should be:

- Clearly achievable within timescales considered
- Published along with final report on the Boards website

15. LEARNING AND DISSEMINATION FOLLOWING A SAFEGUARDING ADULTS REVIEW

Learning and dissemination of learning from Safeguarding Adult Reviews must be effective and relevant. Each agency needs to ensure appropriate and proportionate training takes place.

Appendix 1

Terms of Reference for a Safeguarding Adult Review Subgroup

The Safeguarding Adults Review subgroup (SAR subgroup) is a sub-committee of the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Boards and has powers specifically delegated in these terms of reference.

1. Purpose

To oversee Safeguarding Adults Review functions on behalf of Bournemouth, Poole and Dorset Safeguarding Adults Boards consistent with the Dorset, Bournemouth & Poole Safeguarding Adults Review Policy and ensure they are consistent with national guidance and any relevant local policies.

To set up a task and Finish Group called the Safeguarding Adult Review panel that would carry out Safeguarding Adults Reviews in accordance with Section 44 of the Care Act 2014.

2. Objectives

- To establish whether there are lessons to be learned from cases under review or that could be under review, about the way in which local professions and agencies work together to safeguard adults in vulnerable situations

- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.

- To improve inter-agency working and better safeguarding of adults in vulnerable situations.

- To enable effective communication with all stakeholders to ensure the learning is widely disseminated and family members are informed and involved in the way they wish to be.

3. Specific Remit/Duties

a) Secure compliance with the Dorset Safeguarding Adults Board and the Bournemouth & Poole Safeguarding Adults Board Safeguarding Adults Review Policy

b) Keep the Safeguarding Adult Review Policy (including criteria for reviews) under review; advise on its effectiveness and best practice in the conduct of Safeguarding Adult Reviews.

c) Receive, screen and consider review requests against agreed criteria and make recommendations to the Chair on the need and type (could be proactive or reactive) of Safeguarding Adult Review, to include the methodology used.

d) Identify learning points from Safeguarding Adults Reviews and report on outcomes to the Safeguarding Adults Boards

e) Ensure confidentiality is maintained in relation to information for Safeguarding Adults Reviews and parameters of the Personal Data Exchange Agreement is adhered to

f) Ensure communication and briefing to staff, family members and media as appropriate.

g) Promote transparency and objectivity and ensure declarations of interest and any conflicts of interest are identified at all meetings and during reviews.

h) Clarify, advise and make decisions on the sharing or dissemination of reports (in whole or in part).

i) Ensure notification of other relevant bodies e.g. CQC, Home Office, Coroner and any other relevant professional, government and inspection bodies as required by individual agencies.

j) Report quarterly to the Bournemouth and Poole Safeguarding Adults' Board and the Dorset Safeguarding Adults' Board.

k) Maintain a forward plan of work and set time aside each year to:-

- Review achievements and improvements.
- Assess effectiveness.
- Consider future requirements.

4. Chair, Members, Secretary, Deputies

Chair Independent Chair of the Board

Deputy to be nominated

Members Bournemouth and Poole and/or Dorset Safeguarding Adults Boards:
Director of Adult Social Care - Bournemouth Borough Council
Head of Adult Social Care - Borough of Poole
Director of Quality – Dorset CCG
DCI for Safeguarding, Dorset Police
Service Manager, Safeguarding and Quality, Dorset County Council
Safeguarding Manager - South Western Ambulance Service
Safeguarding lead, Dorset Healthcare NHS University Foundation Trust

Support: Business Manager and MSO BPSAB

5. Quorum/Voting

The panel acts as an advisory group to the Chair who is responsible for making the decision about whether to proceed with a Safeguarding Adult Review.

6. Organisation, Frequency of Meetings, Administration

Meetings to be arranged for every six weeks – may be cancelled if insufficient business.

Business Manager and Management Support Officer for the Bournemouth and Poole Safeguarding Adults Board to provide administration

7. Standing Agenda Items

- Welcome and Apologies
- Minutes and Matters Arising
- Safeguarding Adults Reviews – progress and updates
- Requests for new Safeguarding Adults Reviews
- Progress on Action Plans
- Dissemination
- Any other Business

8. Relationships with Other Committees

This Safeguarding Adult Review subgroup reports to and is a subgroup of the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board.

The subgroup sets up a time-limited Task and Finish group (known as the Safeguarding Adults Review Panel) to work on a particular case using the methodology chosen.

9. Monitoring Effectiveness, Review Date

To be reviewed annually and as requested

10. Document Owner

Date	Contact	Version	Page	Details of Change
23.04.15	Anne Humphries	V4		

Appendix 2

Terms of Reference for the Safeguarding Adults Review Panel (May 2015)

The Safeguarding Adults Review panel is a subgroup of the Safeguarding Adult Review subgroup, which is in turn accountable to the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Boards.

1. Purpose

To carry out a Safeguarding Adults Review on behalf of the Safeguarding Adult Review subgroup of the Boards in accordance with Section 44 of the Care Act 2014.

The Safeguarding Adult Review should be consistent with the Dorset, Bournemouth & Poole Safeguarding Adults Review Policy.

2. Objectives

- To use the chosen methodology and conduct a Safeguarding Adults Review in the timescale given (within 6 months of initiating it unless good reason for a longer period being required).
- To promote an open, reflective learning culture.
- The purpose is NOT to hold organisations (for actions they took in good faith) to account but to learn lessons to prevent similar harm occurring again.
- Establish whether there are lessons to be learned from the case under review or that could be under review, about the way in which local professionals and agencies work together to safeguard adults in vulnerable situations.
- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
- To enable effective communication with all stakeholders to ensure the learning is widely disseminated and family members are informed and involved in the way they wish to be.

3. Specific Remit/Duties

a) Promote a culture of continuous learning across all the organisations taking part in the Review

b) Secure compliance with the Dorset Safeguarding Adults Board and the Bournemouth & Poole Safeguarding Adults Board Safeguarding Adults Review Policy

c) Focus on what needs to happen to achieve understanding, remedial action and answers for family/friends of adults who have died or been seriously abused/neglected

d) Ensure the approach taken to reviews is proportionate according to the scale and level of complexity of issues being examined

e) Conduct the review in a manner that achieves the aim that reviews are trusted and safe experiences that encourage honesty, transparency and sharing information

f) Ensure confidentiality is maintained in relation to information for Safeguarding Adults Reviews and parameters of the Personal Data Exchange Agreement is adhered to

g) Identify learning points from Safeguarding Adults Reviews and report on outcomes to the Safeguarding Adults Review subgroup

h) Put together a draft action plan for the Safeguarding Adults Review subgroup

4. Chair, Members, Secretary, Deputies

Chair to be nominated by the Safeguarding Adult Review subgroup

Deputy to be nominated

Members to be nominated by the Safeguarding Adult Review subgroup

Meetings to be administered by support officers within the relevant Safeguarding Adults Board (e.g. if a Dorset case then Dorset responsible).

4. Quorum/Voting

The panel acts as a working group to the Safeguarding Adults Review subgroup and therefore no voting is required. Any items not resolvable to be referred back to the chair of the Safeguarding Adult Review panel.

5. Organisation, Frequency of Meetings, Administration

Meetings to be arranged to fit the work programme detailed by the Safeguarding Adults Review subgroup.

Meetings to be administered by support officers within the relevant Safeguarding Adults Board (e.g. if a Dorset case then Dorset responsible).

6. Standing Agenda Items

- Welcome and Apologies
- Minutes and Matters Arising
- Agenda items specific to chosen methodology

- Any other Business

7. Relationships with Other Committees

This Safeguarding Adult Review panel reports to the Safeguarding Adult Review subgroup of the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board.

This working group is a time-limited Task and Finish group (known as the Safeguarding Adults Review Panel) to work on a particular case using the methodology chosen by the subgroup.

8. Monitoring Effectiveness, Review Date

To be reviewed annually and as requested

9. Document Owner

Date	Contact	Version	Page	Details of Change
13.5.15	Anne Humphries	V1		

Appendix 3

EXTRACT FROM EXISTING POLICY: Lead Reviewer and Chronology

7) Conduct of Safeguarding Adults Review

7.1 Scoping Meeting – this will agree:-

- The Terms of Reference for the Review
- The agencies, which should be asked to secure their case, records promptly and complete an IMR and individual chronology, timescales covered and the level of detail required.
- The "evidence" or information required from each participant.
- The support and other resources needed
- Time scales within which the review process should be completed.
- Dates, time and venues of meetings.
- The nature and extent of legal advice required, in particular: Data Protection, Freedom of Information and Human Rights Act and Domestic Violence Crime and Victims Act 2004.
- This meeting will decide the point at which the merged chronologies should be undertaken.
- The appointment & funding of the Overview Author

7.2 Briefing meeting – briefing IMR authors.

- Each agency asked to complete an IMR will inform the Chair and Policy & Performance Review Officer of the name of the IMR author(s).
- The IMR authors will be invited to meet with the Panel, to ensure the Terms of Reference for the Review are clear and to identify and resolve any barriers to completing the work.
- Ensure IMR authors have assistance or training if required

7.3 IMR Reports

The IMR authors undertake the work and complete the IMR in a specified timescale, usually 6 weeks from scoping meeting.

7.4 Safeguarding Adults Review – receipt of information meeting or IMR Panel Day.

This stage of the meeting is a formal information sharing session where agencies will be encouraged to query and comment on the reports presented. IMR authors will be invited to a meeting to clarify and raise queries from their reports.

Each agency involved, and IMR authors where appropriate, will be asked to:-

- Present and examine the chronology of events, highlighting any discrepancies.

- Present a comprehensive report of the actions by their agencies.
- Ensure any other management reports and other relevant information is made available.

7.5 Safeguarding Adults Review – discussion of information or 2nd IMR Panel Day.

This stage is where the assessment of whether any new information has come to light that warrants any further action. The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source.
- Examine and identify relevant action points.
- Form a view on practice and procedural issues.
- Agree the key points to be included in the report and the proposals for action.

7.6 Issues Arising

If, at any stage whilst undertaking the procedure contained in 7.4 and 7.5 information is received which requires notification to a statutory body regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

A decision will be made as to whether the Safeguarding Adults Review process should be suspended pending the outcome of such notification.

7.7 Report Stage

The review panel will complete the review of agency management reports and those commissioned from any other source and advise the Chair on the production of an Overview Report, which brings together information, analyses it and makes recommendations. The Chair will have commissioned an independent Overview Report writer, and ensure that the Report is written and delivered within agreed timescales, usually 5 to 6 months from initial decision to proceed.

The Safeguarding Adults Review will consider and quality assure the overview report to ensure it meets the required standard for the Safeguarding Adults Board.

7.8 Acting on the recommendations of the Safeguarding Adults Review

On completion, the Overview Report will be presented to the Safeguarding Adults Board, which will:-

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report.

- Ensure that the Overview Report contains an Executive Summary which can be made public, and consider the need for a professional briefing paper with key learning points for agencies.

- Translate recommendations from the overview report into an action plan, which should be endorsed at senior level by each agency.

7.9 The action plan will indicate:

- Responsibilities for various actions.
- Timescales for completion of actions.
- The intended outcome of the various actions and recommendations.
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems.
- To whom the report or parts of the report should be made available and indicate the means by which this will be carried out.
- The processes for dissemination of the report and/or key findings to interested parties, for the receipt of feedback and for any debriefing to staff, family members and, where appropriate, the media.

7.10 Recommendations

- The Safeguarding Adults Board will ensure that all recommendations are actioned and will request updates from agencies.

- The Action Plan will remain on the Safeguarding Adults Board Agenda until such time as all recommendations have been implemented.

Appendix 4

SCIE Lead Reviewer Model http://www.scie.org.uk/children/learningtogether/

Appendix 5

Hybrid version developed by the Children's Boards locally
http://www.dorsetlscb.co.uk/site/advice-for-people-working-with-children/serious-case-reviews/

Appendix 6

Forms to use when initiating a Safeguarding Adults Review.

Letter requesting a Safeguarding Adult Review

Date:-

F.A.O The Chair of The Safeguarding Adults Board
Dorset County Council
Dorchester Local Office
Acland Road
Dorchester
Dorset
DT1 1SH

OR

FAO – The Chair of the Bournemouth & Poole Safeguarding Adults Board
c/o MSO, Bournemouth & Poole Safeguarding Adults Board
Adult Social Care - Services
Civic Centre
Poole
Dorset BH15 2RU

Dear

I am writing to request that you consider the need for a Safeguarding Adult Review under Dorset, Bournemouth & Poole Adults at Risk Safeguarding Adult Review and Policy. I have given brief details of the case on the attached form.

I look forward to hearing from you,

Yours sincerely,

Person requesting Safeguarding Adult Review

Job Title:
Organisation:
Workplace:
Address:
Contact No:
E-mail:

Other named contact:
Job Title:
Contact No:

Brief Details of incident.
Continue on separate sheet if necessary

Date:	Details:

Agencies known to be involved in case:

Any other information you feel is relevant:

Signed:
Print
Name:
Date:
Cc

You may be contacted for further information if required.

You will be notified in writing of the decision made.

If you have any queries about the process in Dorset please contact the Partnership Officer on telephone number 01305 251414 and in Bournemouth & Poole contact Business Manager on telephone number 01202 261015.

Appendix 7 Clarifying how Organisational Factors can cause incidents

- **Clarify how organisational factors can cause incidents**

  How we think about what causes the failure of partner agencies to work effectively to protect an adult from abuse or neglect, affects how we approach investigating and analysing cases. It also influences the recommendations made to prevent reoccurrence.

  One approach that focuses more on organisational learning and improvement and less on blaming such is the 'Swiss cheese' model which distinguishes between 'active failures' (mistakes practitioners may have made) and 'latent failures' (organisational factors which made it easier for such active errors to be made)

- **Use techniques to avoid hindsight bias in commissioning and quality assuring Safeguarding Adult Review reports**

  The tendency to 'consistently exaggerate what could have been anticipated in foresight' the 'knew it all along' effect is a well researched finding. Knowledge of the outcome biases our judgement about the process that led up to that outcome. In addition:

  - The benefit of hindsight bias leads us to over simplify the situation confronting the practitioners who were involved at the time;

  - We judge decisions or actions that are followed by a negative outcome more harshly than if the same decisions or actions had ended neutrally or well.

  The need to consider possible alternative outcomes of events, even when the actual result is known is one strategy that could be deployed in order to try and avoid hindsight bias.

- **Demonstrate that top management want safeguarding Adult Reviews to 'tell it like it is'**

  It is vital, if organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing information to obtain maximum benefit.

- **Be transparent about how safeguarding Adult Reviews fit with disciplinary procedures.**

  There are real tensions between learning and apportioning blame. In order for Safeguarding Adults Reviews to be genuinely about learning – there needs to be transparency about the interface with individual accountability.