Bexley Safeguarding Adults Board

Statutory Responsibilities for Safeguarding Adults Reviews (SARs) Policy and Procedures Toolkit 2017

Contents

1. Foreword

The Bexley Safeguarding Adults Board recognises and values the opportunity to ensure that the Partnership learns, develops and uses a positive reflective practice approach to inform the development and assurance of safeguarding adults work in the borough.

This Policy and Toolkit is designed to explicitly set out the ***statutory*** roles and responsibilities within Safeguarding Adults Reviews and to clarify the governance arrangements relating to such reviews.

In addition, in Bexley have incorporated the requirements of the Care Act 2014, and are adopting the term, 'Safeguarding Adults Reviews' for all safeguarding learning reviews. Regardless of which methodology is used to achieve learning, all Safeguarding Adults Reviews are of equal significance and value to the BSAB.

Safeguarding Adults Reviews are essential in helping the Board prevent abuse and neglect of adults at risk and learn from cases and situations that challenge us as a multi-agency partnership.

It is everyone's responsibility to safeguard adults at risk and together I am certain we can achieve better outcomes based on the learning we receive. It is important to remember that anyone can make a Notification to the BSAB regarding a serious incident, death or near death experience of an adult at risk.

The Board is proud of the commitment that agencies have demonstrated to the review process and is committed to continue to reflect, learn and develop safeguarding practice in Bexley.

Annie Callanan
Independent Chair – Bexley Safeguarding Adults Board
2017

2. Introduction

The Care Act 2014 states that BSAB's must conduct any Safeguarding Adults Review (SAR) in accordance with Section 44 of the Act.

The purpose of a SAR is to prevent serious harm or the risk of serious harm to adults at risk of abuse or neglect by learning from complex cases that agencies find challenging, which, on initial analysis, demonstrate areas of practice that could have been delivered more effectively and additionally, where there are clear concerns that agencies have not worked as well together as they might.

A SAR is a multi-agency process that considers whether or not serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented and uses that consideration to develop learning that enables the safeguarding adults partnership in Bexley to improve its services and prevent abuse and neglect in the future.

2.1 The Care Act 2014 states "SARs should reflect the six safeguarding principles" these are:

1. **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention** – It is better to take action before harm occurs.
3. **Proportionality** – The least intrusive response appropriate to the risk presented.
4. **Protection** – Support and representation for those in greatest need.
5. **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability** – Accountability and transparency in delivering safeguarding.

This document sets out the BSAB's criteria for conducting a Safeguarding Adults Review (SAR) and options for conducting those reviews. The associated guidance and templates are designed to ensure governance of the process and to provide a process for achieving a complex and challenging task more effectively.

3. Purpose

Safeguarding Adult Reviews (SAR's) provide an opportunity to improve inter-agency working, for onward dissemination of lessons learnt to partner agencies, the sharing of best practice and ultimately better safeguarding of adults at risk of abuse or neglect. They are not enquiries

into how a vulnerable adult died or who is culpable; that is a matter for safeguarding enquiries, Coroners or Criminal Courts to determine, as appropriate.

A SAR will be focused on ensuring learning and improvement of practice and partnership responses to addressing or preventing abuse or neglect of adults at risk. This process is explicitly ***not*** about blaming any agency, service or individual. However, it will be expected of all agencies to embed the learning and its findings with accountability to the Board. It should also be noted that this process is not intended to simply focus on the most dramatic and harmful cases, but on those that afford maximum learning in Bexley.

3.1 The purpose <u>IS</u> to:

- establish the facts
- establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of the adult) work together to safeguard adults at risk
- review the effectiveness of procedures (both multi-agency and those of individual organisations)
- inform and improve local inter-agency practice and commissioning arrangements
- improve practice by acting on learning and developing best practice
- prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

<u>NOT</u> to:

- to reinvestigate or apportion blame.
- to address professional negligence. Should the review identify necessary disciplinary action this should be addressed through agencies' own Disciplinary Procedures. IMR authors therefore need to be cognisant of their agency's disciplinary procedures
- an enquiry into how an adult at risk has died: that is a matter for the Coroner's Court.
- an enquiry into who is culpable for the death of that adult at risk: that is a matter for the Criminal Courts.
- a Judicial Inquiry: there is no oral evidence or cross-examination of that evidence. It is acknowledged that agencies may have their own internal/statutory review procedures to investigate serious incidents; e.g. an NHS Serious Incident Investigation (Appendix 4). This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

4. Conducting SAR's in Bexley

The Serious Adult Review Sub Group of the Bexley Safeguarding Adults Board (BSAB) is responsible for recommending the commissioning of Safeguarding Adults Reviews (SARs), managing the process and assuring the BSAB those recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

4.1 The SAR Sub Group will:

- Collate action points and disseminate to the SAR Sub Group, ensuring that all outstanding actions are delivered and that Lessons Learned are clearly disseminated

- Collate and review recommendations from SAR's from other authorities and best practice research to drive continuous improvement in Bexley

- Collate and review recommendations from all partner internal/statutory reviews i.e. statutory Domestic Homicide Reviews (Appendix 4), Management Reviews, Reflective Practice, Root Cause Analysis and after Action Reviews.

4.2 <u>CRITERIA FOR CONDUCTING A SAFEGUARDING ADULTS REVIEW (see Decision-Making Form):</u>

The BSAB will take the lead for conducting a SAR when:

- An adult at risk dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death; **<u>AND</u>**

- An adult at risk has sustained any of the following:
  - A life threatening injury through abuse or neglect
    Serious sexual abuse
  - Serious or permanent impairment of development through abuse or neglect

<u>OR</u> (one of the following):

- Where there are multiple victims
- Where the abuse occurred in an institutional setting
- A culture of abuse was identified as a factor in the Enquiry

AND The case(s) gives rise to concerns about the way in which local professionals and services worked together to protect and safeguard adult/s at risk.

4.3 In deciding whether a SAR should be conducted in cases other than those involving a death, the following questions should be considered (see Decision-Making Form):

1. Was there clear evidence of a risk of significant harm to an adult at risk that was:
    a. not recognised by agencies or professionals in contact with the adult or perpetrator; **OR**
    b. not shared with others; **OR**
    c. not acted upon appropriately?

2. Was the adult abused/neglected in an institutional setting?

3. Was the adult abused/neglected while being supported by the local authority or a NHS Trust?

4. Does one or more agency or professional consider that their concerns were not taken sufficiently seriously or acted upon or adequately being disseminated, understood or acted upon?

5. Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?

6. Does the case appear to have implications for a range of agencies and/or professionals?

7. Does the case suggest that the SAB may need to change its local policy, protocols or practice guidance, or that protocols and guidance are not

4.4 SAR's in Bexley will be conducted in accordance with the following principles:

- ***Positive reflection***: the intention of SAR's is to conduct learning exercises and improve services; these are not to be conducted with the view of blame towards any individual or specific agency and reviews will highlight positive and innovative practice as well as that which could have been different.

- ***Timeliness***: priority will be given to ensuring that timescales set out are adhered to and reviews are undertaken in timely manner. This will be considered at the point of commissioning or those partners involved in the process will need to prioritise this work.

- ***Impartiality***: the review will be conducted fairly and impartially with evidence of balance and objectivity in all reports.
- ***Thoroughness***: the review process is robust and committed to exploring each of the terms of reference.
- ***Openness and Accountability***: the review and its outcomes will be shared appropriately and the process will be conducted in accordance with the BSAB and member agencies' governance arrangements.
- ***Sensitivity***: SAR's will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).
- ***Confidentiality:*** all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

5. Referral and Decision-Making Process – (see Pathway and Forms to use in Appendices)

NOTE: Any agency or professional may refer a case believed to conform to the criteria and guidance using the **SAR Notification / Screening Form** which sets out the areas of potential learning and the issues that indicate this case requires a review.

5.1 The **SAR Notification / Screening Form** is held on the Bexley Safeguarding Adults Board web page on www.safeguardingadultsinbexley.com and should be sent from a secure email address to: BSAB@bexley.gov.uk (also attached in Appendices at the end of this document for reference).

5.2.1 Where the referrer does not have a secure email address, they should telephone the Safeguarding Adults Board (02030455315) and discuss how best to send the form. This will be acknowledged within one working day and the BSAB Business Team of the Board will contact the referrer to discuss the referral.

5.2.2 The Safeguarding Adults Business Team will send to the BSAB SAR Sub Group Chair and/or Vice Chair to determine within 5 working days whether the referrer will then be sent the **Scoping Form to be completed within 10 working days by the referrer.** If the SAR Sub Group is more than 30 days between meetings, the Sub Group Chair and/or Vice Chair will agree if an extraordinary meeting will be called and the BSAB Business Team will arrange the meeting. The SAR Sub will then make a decision whether or not the referral

meets the criteria then recommendation will be submitted to the Independent Chair of the Safeguarding Adults Board for final decision-making. In the event of a SAR referral being rejected, the reasons need to be recorded in writing by the Independent Chair to the SAR Sub Group and shared with the referrer.

5.3 <u>Recommendations to the Independent Chair of the BSAB (see Decision-Making Form):</u>

In addition to recommending whether or not a review should take place following receipt of a referral, the Safeguarding Adults Review Sub Group will make recommendations to the Independent Chair of the BSAB about:

- Any urgent actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review;
- The overall approach to the Safeguarding Adults Review. Where this has been delegated to a Review Panel, the Sub Group Chair will explain this to the Independent Chair.

5.3.1 Following approval, the SAR Sub Group will be responsible for appointing an Independent Chair for the Safeguarding Adults Review Panel. The Independent Chair will also be the author of the final Overview Report or Executive Summary.

5.3.2 The Decision to Conduct a Safeguarding Adults Review:

All Safeguarding Adults Reviews will be conducted through the Safeguarding Adults Review Sub Group and only the Safeguarding Adults Review Sub Group, with representation from Adult Social Care, Police and Health can recommend a Safeguarding Adults Review.

The Safeguarding Adults Review Sub Group is responsible for making a recommendation to the Independent Chair of the BSAB and that individual will make a decision about whether or not to conduct a Safeguarding Adults Review.

The decision will be communicated to the referrer, the BSAB, the Safeguarding Adults Review Sub Group, the Care Quality Commission and NHS England, where the Review concerns any primary care organisations. The Director of Adult Social Services will also be informed of the decision.

5.4 Safeguarding Adults Review Reports and Action Plans (see Appendices 1 and 2):

All reports of Safeguarding Adults Reviews are owned by the BSAB and held securely by the Bexley Safeguarding Adults Team on behalf of the BSAB. Reports and action plans are only final when accepted by the Independent Board Chair and the BSAB and agreed by the Director of Adult Social Services.

5.4.1 Final Safeguarding Adults Review reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (this will be reflected in the recommendations and action plan);
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

5.4.2 When compiling and preparing to publish reports the BSAB will consider carefully how best to manage the impact of publication on Adult(s) at Risk, family members and others affected by the case. The BSAB will comply with the Data Protection Act 1998 when compiling or publishing the report, and will comply also with any other restrictions on publication of information, such as court orders.

Individual Agency Management Reviews and Reports are owned by the agency that authored them.

The BSAB is responsible for recommending approval of all Safeguarding Adults Review Reports and Action Plans. The Safeguarding Adults Review Sub Group is responsible for monitoring and confirming completion of all Safeguarding Adults Review action plans.

All action plans will explicitly set out how agencies will evidence completion of an action and how the learning from the Safeguarding Adults Review will be embedded within the organisation.

Action plans will be monitored by the Safeguarding Adults Review Sub Group. Any failure to complete actions will be escalated to the Independent Chair of the Board with the knowledge of the relevant BSAB Board member. Where this relates to organisation that is commissioned by the BSAB member, this will also be raised with the commissioner and regulator.

When an action plan has been completed, this will be reported to the BSAB prior to closure of the Safeguarding Adults Review. The Review can only be closed when the BSAB is satisfied and has agreed that all actions have been completed.

5.4.3 There will be a need to address the budgetary requirements for undertaking a Safeguarding Adults Review, the owner of the SAR documents and the SAR Sub Group will Monitor and Evaluate the SAR Learning and Recommendations through partners Action Plans:

- Partners to submit updates quarterly as requested from BSAB SAR Sub Group (within 30 Days of the request).
- Feedback given to Full Board on a quarterly basis and identify areas for BSAB Risk Register (as needed).
- Expectation from BSAB for all partners/agencies to embed and change practice, policy and/or procedures within 3 – 12 months following SAR.
- And comply with any other request from the SAB.

This will be the responsibility of the statutory partners of the Bexley Safeguarding Adults Board.

6 Parallel Statutory Reviews/Pathways:

NOTE: A SAR may be referred even if another statutory review has already been commissioned. The SAR Sub Group and Independent Chair must make a decision on whether or not to proceed. The referral still needs to be made. It is not up to a single-agency to decide what gets referred or not.

6.2 Other types of Statutory Reviews:

- **Domestic Homicide Reviews (DHRs):**
  Where a situation is being considered as a Domestic Homicide Review (DHR) and the case involves an adult at risk of abuse or neglect, the **Community Safety Partnership will automatically refer the case to the BSAB for consideration as a SAR.** This will be referred to the SAR Sub Group as per section 5.1-5.3 above, but that Sub Group will consider whether:
  a. a single SAR led by the BSAB should be undertaken
  b. a recommendation to the DHR with adult safeguarding involvement should be made or
  c. where a decision has already been made for a DHR, a joint review should be undertaken.

- **Children's Safeguarding Board Review:**
  It may be that the Bexley Local Children's Safeguarding Board (LSCB) also conducts a review or is involved in the DHR and/or SAR a key partner to the BSAB or a jointly commissioned SAR may be decided on between Chairs of the LSCB and the BSAB.

- **The Coroner:**

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody (including DOLS), which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk.

These are likely to fall within one of the following categories where:

1) **Obvious and serious failing by one or more organisations;**
2) **No obvious failings, but the actions taken by organisations require further exploration/explanation;**
3) **A death has occurred and there are concerns for others in the same household or other setting (such as a care home);**

Or

4) **Deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.**

<u>NOTE</u>: If HM Coroner contacts the BSAB and/or its partner(s) about any of these situations, the SAR Sub Group Chair must be informed through the Notification Form to the BSAB Business Team as per usual pathway for SAR consideration.

7. Embedding Learning: The purpose of a Safeguarding Adults Review is to learn and improve practice and services. It is essential therefore that the learning from Safeguarding Adults Reviews is widely disseminated.

7.1 Learning from Safeguarding Adults Reviews will be disseminated and agreed through the BSAB Communication Strategy, for example:

- Via a BSAB Bulletin
- Through regular Learning from Practice Events
- Through the BSAB Training Development Sub Group
- At post-review learning dissemination workshops
- By publication on the Bexley Safeguarding Adults Board Website
- Through an Safeguarding Adults annual report, which highlights learning themes in both local and national reviews
- By individual agencies taking responsibility to share learning internally.

7.2 The Safeguarding Adults Review Sub Group will report thematic learning on an annual basis to the BSAB's Performance Management and Quality Assurance Sub Group and this will inform the key indicators for the strategy plan and key work programme of the BSAB.

8. Recommending the Overall Approach to the Safeguarding Adults Review -

All reviews will establish a Review Panel, of whatever size is required in relation to its complexity; this is either the Sub Group or an allocated Review Panel of key partners to recommend:

- Which agencies should be asked to participate in the SAR;
- Whether the agencies concerned are required to secure their files;
- Which methodology should be used to facilitate learning in the case;
- The Terms of Reference for the SAR (including the time-span of the review);
- The required output from the SAR (e.g. a report);
- The timescales for completion of the SAR;
- Whether the SAR requires an Independent Facilitator or Chair, or if this role should be undertaken by the Bexley Safeguarding Adults Partnership Support Unit or a BSAB member agency;
- Whether an independent author is required and if so, whether this role should be undertaken by the Safeguarding Adults Team, a BSAB member agency or someone entirely independent.

9. Specific Roles & Responsibilities / BSAB Governance:

9.1 Table:

Role	Responsibilities
Independent Chair of the BSAB	The Independent Chair of the BSAB is responsible for making a decision in response to the Safeguarding Adults Review Sub Group's recommendations for a Safeguarding Adults Review and its associated methodology etc. The Independent Chair of the BSAB is responsible for ensuring the Board receives regular updates in respect of progress of Safeguarding Adults Reviews.
Bexley Safeguarding Adults Board Single-points of Contact (SPOCS)	Members of the Bexley Safeguarding Adults Board (BSAB) will nominate senior appropriately experienced and senior staff to participate in safeguarding adults reviews in consultation with their agency's senior responsible manager. Members of the BSAB will consult regularly with that staffs from their agency that are participating in Safeguarding Adults Reviews to ensure they are informed but also can provide support and guidance. BSAB members should recognise that both these roles are exceptionally time-consuming and challenging and have a responsibility to ensure that their organisation provides these people with protected time and appropriate support to enable them to perform effectively in these roles. The BSAB is responsible for recommending to the Director of Adult Social Services approval of all Safeguarding Adults Review reports and action plans. BSAB members are responsible for ensuring their organisation's actions within SAR's multi-agency action plans are achieved.
Safeguarding Adults Review Panel Members	Members of a Safeguarding Adults Review panel will be nominated by their BSAB member and senior agency manager to work together in considering the issues within the Safeguarding Adults Review. Safeguarding Adults Review Panel members will be senior managers without line management responsibility for the case and without previous involvement in the matter. However, they will be people with the ability and seniority to effect real change in their organisation and to influence others in the Review to effect change across the Partnership.

	Where this role has been delegated by the Safeguarding Adults Review Sub Group, the Review Panel will recommend the detail of the approach to the review, including, timescales, terms of reference, methodology etc. Members of the Safeguarding Adults Review Panel will feedback to their agency's BSAB member on progress and key issues emerging from the Review.
BSAB Safeguarding Adults Review Sub Group	The SAR Sub Group is responsible for recommending to the Independent Chair of the BSAB whether a referral for a Safeguarding Adults Review meets the criteria. This recommendation will clearly state the reasons for this recommendation. The Independent Chair will consider the information provided by the Safeguarding Adults Review Sub Group and decide whether or not to conduct a Safeguarding Adults Review. If the criterion is met and a SAR agreed the SAR Sub Group is responsible for performance managing the Safeguarding Adults Review process and reporting progress to the BSAB at each of its meetings. The SAR Sub Group is responsible for monitoring and recommending to the BSAB completion of Safeguarding Adults Review action plans.
Safeguarding Adults Review Chair	Where the Safeguarding Adults Review requires a chair, the role may be undertaken by either a member of the Safeguarding Adults Review Sub Group, or another experienced individual who is identified by the Sub Group. The Safeguarding Adults Review Chair will be responsible for achieving consensus of opinion about the key areas of learning and areas of change within the Review. The Chair will be accountable to the Safeguarding Adults Review Sub Group and will need to keep that person regularly informed of the progress of the Review in order that the BSAB is briefed. The Safeguarding Adults Review Chair is responsible for helping those participating in a Safeguarding Adults Review work together positively; providing appropriate challenge and focusing on good practice as well as areas of development and ensuring this is reflected in any accompanying report. The BSAB firmly believes that Safeguarding Adults Reviews should be focused on mutual reflection, learning and development, not blame or criticism and it is the Safeguarding Adults Review Chair's role to ensure this principle is adhered to within every aspect of the Review.

	The Safeguarding Adults Review Chair is responsible, together with the Chair of the Sub Group, for presenting Safeguarding Adults Review reports and action plans to the Independent Chair of the BSAB for consideration and recommendation to the Board.
Independent Author	Where an Independent Author is required in a Review will be appointed from the BSAB approved pool of authors to write an independent Safeguarding Adults Review Report on behalf of the BSAB where this is an agreed output of a Safeguarding Adults Review. The Independent Author will work with members of the Safeguarding Adults Review to address each of the Terms of Reference of the Review and produce an Overview Report. This Report will have recommendations that are agreed by the Safeguarding Adults Review Panel. These will be SMART and will provide the BSAB with positive learning that will enable it to improve services and safeguarding in the borough.
Adult(s) at Risk, Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and Significant Others	The Adult(s) at Risk, Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and other people close to the Adult(s) at Risk have a valuable role in the Safeguarding Adults Review process and the BSAB values the importance of their views and also recognises that the process can be difficult. As such, the Safeguarding Adults Review Sub Group will offer to meet with those individuals, as agreed appropriate as soon as the decision has been made to proceed with a Safeguarding Adults Review in order to hear their views and explain the process, highlighting the purpose of the Review and signposting them to other routes if they wish make a complaint. Similarly it may be appropriate for the views of the Adult at Risk themselves, if possible and Person(s) or Organisation(s) Alleged Responsible to be fed into the Review. The Safeguarding Adults Review Sub Group will keep all relevant individuals regularly informed of progress through the review. At the conclusion of the Safeguarding Adults Review, once relevant reports and plans have been accepted by the Independent Board Chair, the BSAB and the Director of Adult Social Services, the Independent Chair of the Board and the Chair of the Safeguarding Adults Review Sub Group will offer to meet with these people to explain the Review conclusions.
Director of Adult Social Services (DASS)	The Director of Adult Social Services has the statutory role in relation to safeguarding adults in the Borough and therefore this person is ultimately responsible for all Safeguarding Adults Reviews. The Independent Chair of the BSAB and the Chair of the Safeguarding Adults Review Sub Group will ensure the Director of Adult Social Services is advised of all Safeguarding Adults Review referrals and decisions.

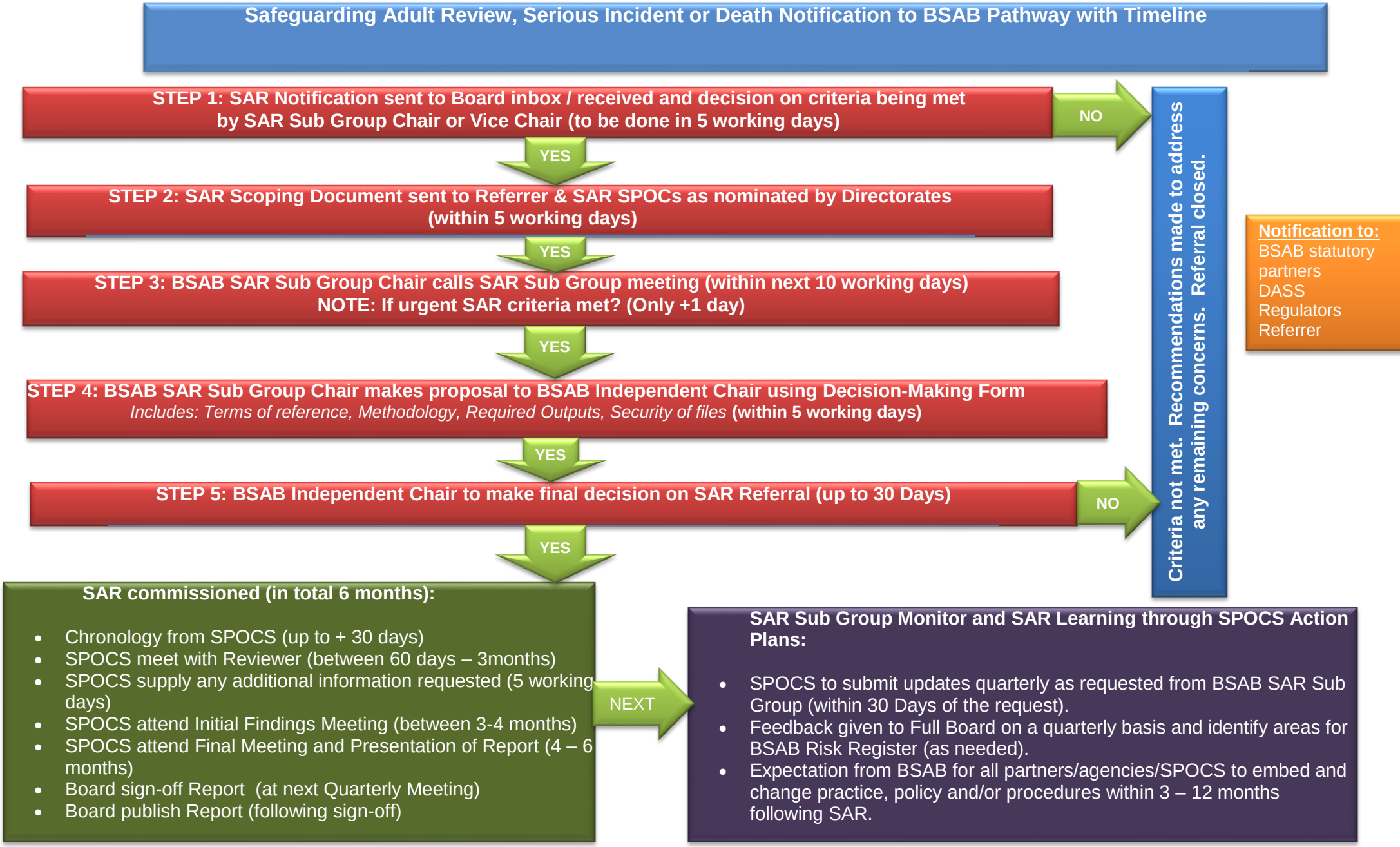
	Where a Safeguarding Adults Review has a report of its findings, this will be approved by the Director of Adult Social Services, together in consultation with the Independent Chair of the BSAB and the Chair of the Safeguarding Adults Review Sub Group. The Director of Adult Social Services is ultimately responsible for approving the report. Where relevant, Bexley Council will be responsible for holding a joint BSAB press statement / release as necessary on behalf of the Board. The Director of Adult Social Services will meet with the Chair of the Safeguarding Adults Review Sub Group, the Independent Chair of the Board, Board Business Manager and the Head Safeguarding Adults on an annual basis to consider the learning from all Safeguarding Adults Reviews during that period.

9.2 Governance Safeguarding Adults Review Sub Group:

The SAR Sub Group is accountable to the BSAB and this accountability is set out in the Board's Memorandum of Understanding. The Chair of the Safeguarding Adults Review Sub Group will ensure the Independent Chair of the Board and Director of Adult Social Services are informed of any referrals for Safeguarding Adults Reviews, significant developments and progress of reviews.

An overview of each SAR will be reported to each meeting of the BSAB.

Appendix 1:


Safeguarding Adult Review, Serious Incident or Death Notification to BSAB Pathway with Timeline
STEP 1: SAR Notification sent to Board inbox / received and decision on criteria being met by SAR Sub Group Chair or Vice Chair (to be done in 5 working days)
NO
YES
STEP 2: SAR Scoping Document sent to Referrer & SAR SPOCs as nominated by Directorates (within 5 working days)
YES
STEP 3: BSAB SAR Sub Group Chair calls SAR Sub Group meeting (within next 10 working days)
NOTE: If urgent SAR criteria met? (Only +1 day)
YES
STEP 4: BSAB SAR Sub Group Chair makes proposal to BSAB Independent Chair using Decision-Making Form
Includes: Terms of reference, Methodology, Required Outputs, Security of files (within 5 working days)
YES
STEP 5: BSAB Independent Chair to make final decision on SAR Referral (up to 30 Days)
NO
YES
Criteria not met. Recommendations made to address any remaining concerns. Referral closed.
Notification to:
BSAB statutory partners
DASS
Regulators
Referrer
SAR commissioned (in total 6 months):
Chronology from SPOCS (up to + 30 days)
SPOCS meet with Reviewer (between 60 days – 3months)
SPOCS supply any additional information requested (5 working days)
SPOCS attend Initial Findings Meeting (between 3-4 months)
SPOCS attend Final Meeting and Presentation of Report (4 – 6 months)
Board sign-off Report (at next Quarterly Meeting)
Board publish Report (following sign-off)
NEXT
SAR Sub Group Monitor and SAR Learning through SPOCS Action Plans:
SPOCS to submit updates quarterly as requested from BSAB SAR Sub Group (within 30 Days of the request).
Feedback given to Full Board on a quarterly basis and identify areas for BSAB Risk Register (as needed).
Expectation from BSAB for all partners/agencies/SPOCS to embed and change practice, policy and/or procedures within 3 – 12 months following SAR.

Appendix 2:

Methodologies and Recommendations to the Independent Chair of the BSAB:

The BSAB is clear that there are many ways for the Partnership to achieve learning; recent guidance for Directors of Adult Social Services by the Association of Directors of Adult Social Services (ADASS) emphasises the importance of ***proportionality*** in conducting reviews and proposes that Boards have a range of options to match against the circumstances of the case.

The BSAB fully endorses this approach and the Safeguarding Adults Review Sub Group is asked to consider various different ways of enabling learning when recommending a Safeguarding Adults Review. The BSAB is clear that each methodology is valid in itself and no approach should be seen as more serious or holding more importance or value than another.

Possible methodologies for Safeguarding Adults Reviews are set out below. This list is not exhaustive and the SAR Sub Group will recommend the most appropriate learning method of the case under consideration. Regardless of which methodology is used, contributing agencies need to be mindful that there may be public scrutiny of information provided by agencies to the Safeguarding Adults Review and, in particular, HM Coroner may request information. All agencies should ensure, therefore that they ensure that senior managers approve any written submissions to a Safeguarding Adults Review and where they consider it appropriate, seek legal advice prior to submission.

Examples of Methodologies:

1. Significant Event Analysis or Audit:

This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.

The process followed in a Significant Event Analysis or Audit is as follows:

- Information Gathering – collation of as much factual information about the event as possible from a range of sources.
- Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment.
- Analysis of the Significant Event: The key questions that require answering in a Significant Event Analysis or Audit are:

- How could things have been different?
- What can be learned from what happened?
- What has been learned?
- What has been changed or actioned?

2. Systems Review:

The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.

This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice.

It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

A systems approach to conducting a Safeguarding Adults Review involves:

- 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 the BSAB; 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 learned and recommendations

- Event to consider first draft of the overview report and action plan
- Final overview report presented to BSAB, agree dissemination of learning and monitoring of implementation
- Follow up event to consider action plan recommendations
- On-going monitoring via the BSAB.

3. Using Individual Management Reviews to Analyse Individual Agency Performance:

Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced.
Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.

Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

4. Multi-agency Combined Chronology:

Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.

Chronologies are important tools that are particularly useful when combined across agencies using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change.

These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

5. Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel:

It maybe that the Sub Group considers that the best way address a complex case if for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding. This method will provide a detailed analysis of agencies' work with an adult or group of adults and provide a familiar approach to learning; the SAR Sub Group will give very careful consideration to any added value achieved through this approach.

Safeguarding Adults Reviews are resource-intensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

Appendix 3:

Individual Management Review Guidance

1. Aim -

The aim of an Individual Management Review (IMR) is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working
- Identify whether the case indicates that changes to practice could and should be made
- Identify how those changes will be brought about
- Identify examples of good practice within agencies

The exact issues to be addressed in each IMR will be identified by the terms of reference provided by the Review Panel.

2. Authors -

Individual Management Review (IMR) authors will be individuals with expertise in writing objective, learning-focused reports. They will be nominated by their agency's BSAB member and senior responsible manager. They will have had no previous, relevant involvement in the case. IMR authors are responsible for their report, but the overall responsibility lies with the senior manager who authorises the IMR's submission.

3. Process -

- ✓ **Write the chronology:** The chronology assembles the records of agency involvement into a simplified format, ordered by date. The information should be brief and should not go into personal detail. This will guide the process of interviews, and be merged with the chronologies of other agencies.

- ✓ **Conduct a desk-based review:** Before evaluating the agency's involvement any further, the IMR author should assure him/herself that they are familiar with:
  - The agency's policies and procedures
  - Any relevant partnership / multi-agency policies and protocols
  - Professional standards and good practice
  - National and local research and evidence-based practice

- ✓ **Interview staff:** The IMR author should then arrange to interview the staff members who had contact with the key individuals in the case. The interview should cover the staff member's involvement, how they arrived at any decisions regarding the Adult(s) at Risk, Person(s) Alleged Responsible and other key individuals and whether the agency's policies and procedures were followed.
    - The IMR author should be sensitive to the fact that the interview may be difficult for the staff member. The staff member may wish to be accompanied by an appropriate supporter.
    - A written record should be made of each interview and shared with the interviewee and any other people present.
- ✓ **Disciplinary and complaint investigations:** The overall Safeguarding Adults Review is not part of any disciplinary inquiry, but information that emerges in the course of an IMR may indicate that disciplinary action should be taken under established procedures.
    - Alternatively, reviews may be conducted concurrently with disciplinary action. This is a matter for agencies to decide in accordance with their disciplinary procedures. The same consideration should be taken in relation to complaint procedures underway against any single agency.
- ✓ **Writing the IMR report and recommendations:** The IMR author must then analyse the information gathered through the desk-based review and the interviews and produce a report and recommendations. A template for the report is provided; see also the section on recommendations below.
    - NHS organisations may wish to feed their information in to a single IMR author, who will produce a health overview report. This can follow the IMR template, but may not be as detailed. Commissioning within the health service should be considered as part of the analysis and recommendations. Recommendations should be clearly directed to one or more parts of the health service.
    - If the analysis indicates that policies and procedures have not been followed, relevant staff or managers should be re-interviewed to understand the reasons for this.
- ✓ **Quality Assurance:** The senior manager responsible for the Review within the agency should quality-assure the IMR report and recommendations and approve its submission.
- ✓ **Feedback:** Once the report and recommendations are finalised, the senior manager should debrief the staff who have been involved in the Review. There should also be a second feedback session after the Safeguarding Adults Review has completed.

- ✓ **Implementation of recommendations:** The senior manager must then take forward the actions recommended as a result of the IMR. The IMR recommendations should be implemented immediately, and not wait for the conclusion of the overall Safeguarding Adults Review process.

- ✓ **Confidentiality:** IMR authors, Safeguarding Adults Review panel members and any others involved with the review process need to be clear that the information they learn about the case and agency's involvement is confidential. This means it should not be discussed with anyone apart from key agency officers within the agency who are responsible for either the current case management, where information is required to manage the case, or the senior managers in the agency who need to be kept informed in order to achieve the agency's approval.

    - It is vital that documents related to the Safeguarding Adults Review are stored securely with restricted access. Electronic documents must be password protected and access restricted.

4. Content: - The minimum content is set out in the IMR template. Briefly, it comprises an introduction, a comprehensive chronology, analysis of the agency's involvement, a conclusion and recommendations.

However, the overall aim is to find existing good practice and points for improvement, which will ultimately serve to improve safeguarding adults in Leeds. It is therefore worth expending as much effort as reasonably possible to produce an excellent IMR.
An excellent IMR will have the following features, but also refer the IMR checklist.

- The report is a comprehensive and well-structured management review of the agency's full involvement with the key individuals in the Safeguarding Adults Review.
- The review takes full account of the outcomes for the Adult(s) at Risk and Person(s) Alleged Responsible concerned in light of their individual needs and their racial, cultural, linguistic and religious identity.
- Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.
- Good practice is highlighted with appropriate consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.

5. Recommendations - The recommendations are the result of the analysis of the agency's involvement and seek to address any failings identified, or extend any Limited to a single action per recommendation, stating who should do it.

This relates to measuring whether the recommendation has been met or not, so we can say it has been done x many times or improved by y%.

It needs to be achievable in the real world, taking account of the financial and other resources available. A realistic timescale should be included, terms such as 'ASAP' or 'On-going' are not acceptable. Include a recommendation about how the agency will understand the impact the recommended changes have had. Include a recommendation about how the agency will know it has improved its service or practice as a result of learning from this IMR, and the changes are fully embedded Good practice more widely.

Serious Adult Review (SAR) Notification & Screening Form:

Screening Questions (tick one):	Yes	No
1. Is the adult at risk of dying or has died? (includes death by suicide)		
2. Has the adult faced any serious sexual abuse or a life threatening injury/illness through abuse or neglect?		
3. Was the adult neglected/abused in an institutional or home care setting?		
4. Was the adult abused/neglected by more than one person?		
5. Did the adult suffer any serious or permanent impairment of development through abuse or neglect?		
6. Has your agency undertaken any form of learning/incident review in relation to this case?		

Details of the person completing this form:
Name:
Agency:
Email:
Phone number:

Submit this form to the Bexley Safeguarding Adults Board (BSAB) inbox – bsab@bexley.gov.uk and the BSAB Manager will get in touch with you within 5 working days of the date sent.

Further information on can be found on the BSAB website – http://www.safeguardingadultsinbexley.com

Bexley Safeguarding Adults Board

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Safeguarding Adults Review Scoping Enquiry Form

Strictly Private & Confidential

Please complete this form and return it via secure email to: Bexley Safeguarding Adults Board (BSAB) at BSAB@bexley.gov.uk **This information will be used by the Safeguarding Adults Review Sub Group to inform the decision about whether or not any form of review should be undertaken by the Bexley SAB.** **Please answer briefly the questions below and return via secure email to Bexley Safeguarding Adults Board (BSAB) at BSAB@bexley.gov.uk.** **If you have any questions or wish to discuss this in any way please contact Business Manager for the Board at 0203 045 5315.**	
Safeguarding Adults Review Scoping Enquiry	
Referrer:	
Adult(s) at Risk **Name:** **DOB:** **DOD:** **Address:**	
Person(s)/Organisations(s) Alleged to have Caused Harm: **Name:** **DOB:** **Address:**	
Other relevant family/friends:	
Referral reason:	
Scoping referral sent to (list agencies/services):	
Responding Agency: **Name of person completing form:** **Job Title:** **Contact details:**	
Question	**Response**

Period under consideration:	
Did your agency have any contact with the above Adult(s) at risk?	
If so, in what capacity? *(Please detail all services)*	
Has your agency identified any safeguarding concerns in relation to or any other family member/ significant other? *(Please detail)*	
Has your agency identified any areas of learning in the way in which services were provided to this person(s)?	
Has your agency undertaken any form of learning/incident review in relation to this case? *(if so, please detail, inc. any recommendations and actual/anticipated impact)*	
Is your agency aware of the view that any form of multi-agency review should be undertaken? *(Please explain your response).*	
Please detail any other information/comment that you consider would assist the Sub Group in deciding how to respond to this referral.	

Bexley Safeguarding Adults Board

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SAR SUB GROUP DECISION-MAKING FORM

The BSAB via the SAR Sub Group will consider undertaking a Safeguarding Adults Review when it is known or suspected that:

SAR UNIQUE INDENTIFIER:

1. Actions or omissions **in a** ***number of agencies*** **involved in the provision of care, support or safeguarding of an adult, or group of adults, at risk of abuse or neglect** ***have caused or are implicated*** **in the death or serious harm of that individual or group of individuals.**	**Yes**	**No**
If YES, a recommendation for SAR to Independent Chair for decision-making. **OR** **If no, see point 2 below:**		
2. An adult or group of adults at risk die or experience serious harm and there are concerns about how agencies have ***worked together*** **to** ***prevent, identify, minimise or address*** **that harm and there are concerns about how this may** ***place other adults at risk of serious harm*****;** ***And*** **There are clearly identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.**	**Yes**	**No**
If YES, a recommendation for SAR to Independent Chair for decision-making. **OR** **If NO, a recommendation not to proceed with SAR is made to the Independent Chair for decision-making.**		
If it is still unclear whether a SAR should be conducted in cases other than those involving a death, the following questions should be considered; and a positive response to several is likely to indicate that a SAR should be conducted:		
9. Was there clear evidence of a risk of significant harm to an adult at risk that was: **d. not recognised by agencies or professionals in contact with the adult or perpetrator; OR** **e. not shared with others; OR** **f. not acted upon appropriately?**	**Yes**	**No**
10. Was the adult abused/neglected in an institutional setting?	**Yes**	**No**
11. Was the adult abused/neglected while being supported by the Local Authority or a NHS Trust?	**Yes**	**No**
12. Does one or more agency or professional consider that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?	**Yes**	**No**
13. Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?	**Yes**	**No**
14. Does the case appear to have implications for a range of agencies and/or professionals?	**Yes**	**No**
15. Does the case suggest that the SAB may need to change its local policy, protocols or practice guidance, or that protocols and guidance are not adequately being disseminated, understood or acted upon?	**Yes**	**No**

When making a recommendation for SAR to the Independent Chair, the SAR Sub Group should identify the following for the decision-making:	
Which agencies should be asked to participate in the SAR;	
Whether the agencies concerned are required to secure their files;	
Which methodology should be used to facilitate learning in the case;	
The Terms of Reference for the SAR (including the time-span of the review);	
The required output from the SAR (e.g. a report);	
The timescales for completion of the SAR;	
Whether the SAR requires an Independent Facilitator or Chair, or if this role should be undertaken by the Bexley Safeguarding Adults Partnership Support Unit or a BSAB member agency;	
Whether an independent author is required and if so, whether this role should be undertaken by the Safeguarding Adults Team, a BSAB member agency or someone entirely independent.	

ACTION:	
Decision to recommend a SAR:	**YES or NO**
SAR Sub Group Chair sign-off:	**Date:**
Sent to Independent Chair on:	
Independent Chair decision:	

Bexley Safeguarding Adults Board

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Individual Management Review Form - Safeguarding Adults Review

Name of Agency:

Name of adult(s) at risk:

DOB:

DOD (if applicable):

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

1. Factual/Contextual Summary

Provide a brief factual and contextual summary of your Agency's involvement with the adult(s) at risk for the time period identified for this Safeguarding Adults Review.

Factual Summary of Agency Involvement

2. Chronology of Agency Involvement

This will need to be completed on the Chronology Template provided (Annex 4).

What was your Agency's involvement with the adult at risk and/or person who caused harm?

Construct a chronology of involvement by your agency and/or professional(s) in contact with the adult(s) at risk and/or alleged person(s) who caused harm over the period of time set out in the review's terms of reference.

Please identify (in Annex 2) the details of the professionals from within your agency who were involved with the adult(s) at risk and/or person(s) who caused harm, and whether they were interviewed or not for the purposes of this Internal Management Review.

3. Analysis of Involvement

Consider the events that occurred, the decisions made, and the actions taken or not. Where judgments were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Please use the template provided, and if one section does not apply to your agency then identify that this is the case in the appropriate box. Otherwise try to respond to the questions as fully as possible, clarifying the evidence for your views where applicable.

Consider specifically:

Were practitioners sensitive to the needs of the adult(s) at risk in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?

Did the agency have in place policies and procedures for Safeguarding Adults and acting on concerns about their welfare?

What were the key relevant points/ opportunities for assessment and decision making in this case in relation to the adult at risk and/or alleged person causing harm? Do assessments and decisions appear to have been reached in an informed and professional way?

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

Where relevant, were appropriate Safeguarding Adults protection plans or care plans in place, reviewing processes complied with?

When, and in what way, were the adult(s) at risk wishes and feelings ascertained and considered? Was this information recorded?

Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult(s) at risk?

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

Was the work in this case consistent with agency and Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, and wider professional standards?

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

Additionally:

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

What do we learn from this case?

Are there lessons to be learned from this case for the way in which your agency works to protect adults at risk and promote their welfare?

Is there good practice to highlight, as well as ways in which practice can be improved?

Are there implications for ways of working; training (single and inter-agency), management and supervision, working in partnership with other agencies and resources?

Recommendations for Action:

What action will your Agency take, by whom, and by when?

What outcomes should these actions bring about?

How will the agency review whether they have been achieved?

Finally:

Any other comments or information that you wish the Safeguarding Adults Review Panel to consider?

Individual Management Review (Agency) Professionals Involved

Name	Designation	Dates/Period Of Involvement	Type of Involvement	Interview Yes/No	Interview Date

Individual Management Review – Document source.

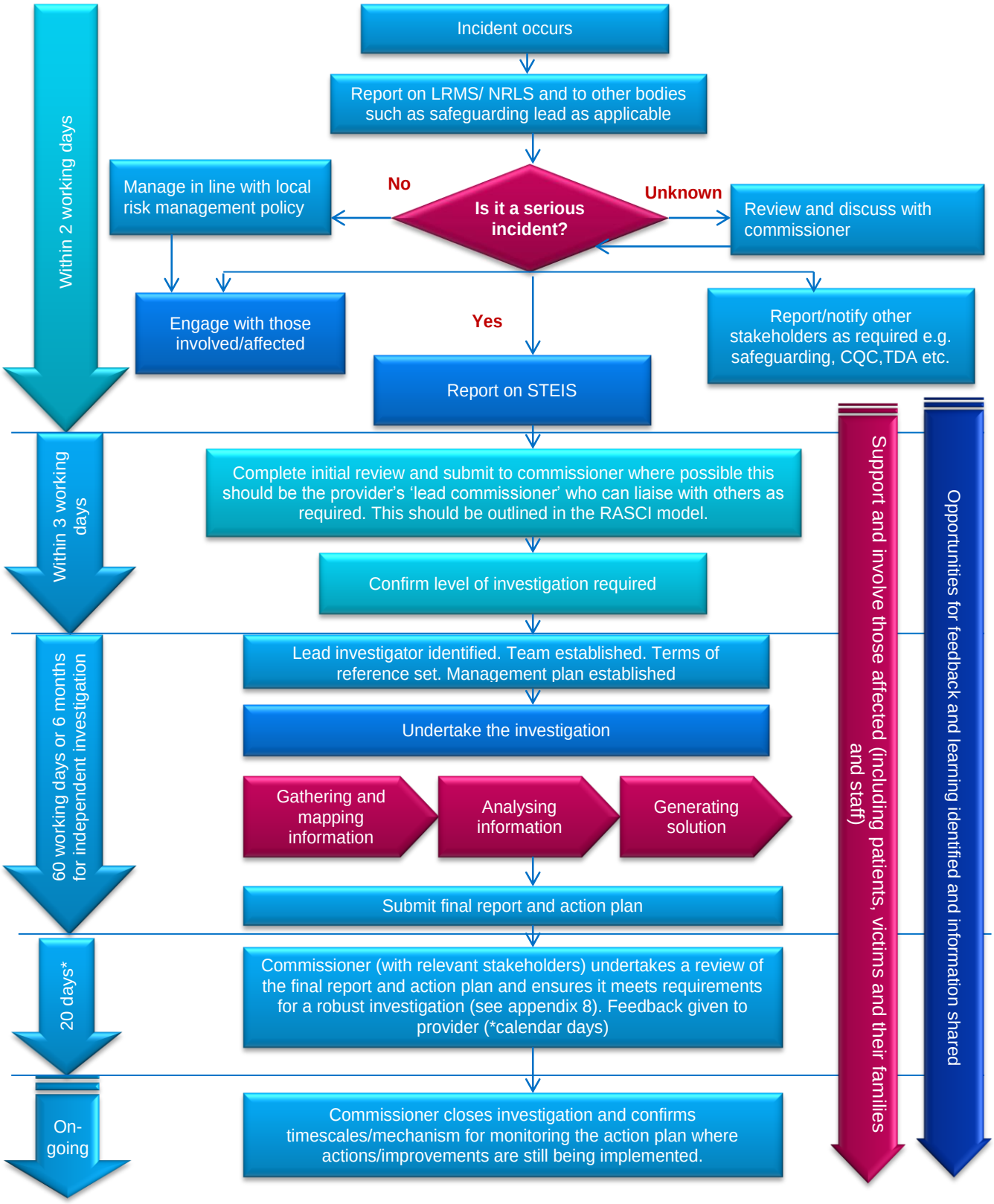
Please list all source documents you have used in completing your Individual Management Review.

Document	Source

NOTE: The information which is required under each heading should be fairly self-explanatory. The last column “comments” should be used if the Agency Reviewer wishes to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue.

Date	Source of evidence	Contact (with Initials)	Name of professional	Reason	Incident/ contact location	Action taken/decision made	Comment

Appendix 6: NHS England - The Serious Incident Management Process



Appendix 7: Domestic Homicide Review (DHR) - Setting up a review: the role of community safety partnerships (CSPs)

When a domestic homicide happens, the police should inform the relevant community safety partnership (CSP) in writing of the incident. The CSP then has the overall responsibility for setting up a review. CSPs are ideally placed to initiate a domestic homicide review and review panel due to their multi-agency design and locations across England and Wales.

Deciding which CSP is responsible

Where partner agencies of more than one local authority area have known about or had contact with the victim, the local authority area where the victim was resident should take responsibility for carrying out any review.

If the victim was of no fixed address before the incident took place, lead responsibility will lie with the area that they were last known to have lived or frequented as a first option, and then considered on a case-by-case basis.

Any professional or agency may refer such a case to the CSP in writing if it is believed that there are important lessons for inter-agency working to be learned from the case.

Deciding whether a review should take place

The chair of the community safety partnership (CSP) is responsible for:

- establishing whether a case is to be subject of a domestic homicide review by applying the definition set out in the guidelines
- the final decision on whether a review should be conducted. This decision should be taken in consultation with local partners with an understanding of the dynamics of domestic violence

Confirmation of a decision to review, as well as a decision not to review a homicide, should be sent in writing to the Home Office domestic homicide review enquiries inbox: DHRENQUIRIES@homeoffice.gsi.gov.uk

As stated at Section 9 (2) of the Act, the Secretary of State may in a particular homicide direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review. Such a direction is likely to be made where a person or body has declined involvement in a domestic homicide review. In such circumstances, the Home Office quality assurance group will liaise with the relevant person or body to ensure action is taken as directed. When victims of domestic homicide are aged between 16 and 18, a child serious case review (SCR) should take precedent over a domestic homicide review.

However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the SCR includes representatives with a thorough understanding of domestic violence.

Circumstances of particular concern

The following factors are some examples of the types of situations preceding homicide which will be of interest to review teams when conducting a domestic homicide review:

- there was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim or the perpetrator, and was not shared with others or it was not acted upon in accordance with their recognised best professional practice.
- any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.
- the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.
- the victim was being managed by, or should have been referred to a multi-agency risk assessment conference (MARAC).
- the homicide appears to have implications or reputational issues for a range of agencies and professionals.
- the homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
- the perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and therefore the homicide is likely to have a significant impact on public confidence.
- the victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

Setting up a panel to conduct the review

When the community safety partnership (CSP) agrees the criteria for a domestic homicide review are met and should be undertaken, they will use local contacts and request that a review panel is set up.

The review panel can either have a fixed, standing membership or can be tailored for the purposes of a particular domestic homicide review. It should include individuals from both statutory and voluntary agencies.

The voluntary sector may have valuable information on the victim or perpetrator and the importance of having agencies to represent the victim. Independent domestic violence advisers (IDVAs) and specialist domestic violence services are key representatives to include on the review panel.

Many CSP areas will already have established local forums that deal with domestic violence and hold a wealth of knowledge in understanding its complexities. Practitioners from these forums should also be invited to join the review panel. Where appropriate, the CSP may wish to refer the DHR for action to such a forum to lead on and manage the review, for example a domestic violence forum.

Members of agencies who have responsibilities for completing individual management reviews can also be members of the review panel, but the panel should not be made up solely of these people.

The review panel should bear in mind all equality and diversity issues at all times; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation may all have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

Relevant agencies

The persons and bodies that have a duty to establish or participate in a domestic homicide review if directed to do so by the Secretary of State include (for England and Wales):

- chief officers of police for police areas in England and Wales
- local authorities
- local probation boards established under Section 4 of the Criminal Justice and Court Services Act 2000 (c 43)
- strategic health authorities established under [Section 13 of the National Health Service Act 2006]
- primary care trusts established under [Section 18] of that Act
- providers of probation services
- local health boards established under [Section 11 of the National Health Service (Wales) Act 2006]
- NHS trusts established under [Section 25 of the National Health Service Act 2006 or Section 18 of the National Health Service (Wales) Act 2006

There are other agencies that may have a key role to play in the review process but are not named in legislation, for example, representatives from the Crown Prosecution Service (CPS), housing associations and social landlords, the HM prison service. Involvement with other agenices will need to be decided on a case-by-case basis and should be agreed by the review panel.

Appointing a chair for the review panel

The review panel should appoint an independent chair of the panel who is responsible for managing and co-ordinating the review process and for producing the final overview report based on individual management reviews and any other evidence the review panel decides is relevant.

The review panel chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review.

Some areas may wish to develop a regional agreement where experienced individuals from neighbouring areas are exchanged or loaned to the review panel to help share good practice and promote the sharing of new information and learning.

Skills and expertise needed to chair a review

When appointing a chair, consideration should be given to the skills and expertise required to effectively chair a review.

The following are guidelines to what is needed:

- relevant knowledge of domestic violence issues including ‘honour’-based violence, research, guidance and legislation relating to adults and children, including the Equality Act 2010
- an understanding of the role and context of the main agencies likely to be involved in the review
- managerial expertise
- good investigative, interviewing and communication skills
- an understanding of the discipline regimes within participating agencies
- the completion of this e-learning training package on domestic homicide reviews, including the additional modules on chairing reviews and producing overview reports

Timescales for conducting a domestic homicide review

In all cases, where lessons can be drawn out they should be acted upon as quickly as possible without necessarily waiting for the review to be completed.

The decision to hold a review should be taken by the chair of the community safety partnership (CSP) within 1 month of a case coming to their attention. The terms of reference for the review should also be drafted and agreed within this timescale.

Individual agencies should quickly secure case records and begin to draw up a chronology of involvement with the victim, perpetrator and their families.

The overview report should be completed within a further 6 months of the date of the decision to proceed unless another timescale is formally agreed with the relevant CSP.

Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it becomes clear that the timescales can't be met (perhaps because of judicial proceedings), the review panel should notify the CSP to renegotiate the timescale for completion.

If the CSP believes that the delay to completion of the review is unreasonable they should refer the issue to the quality assurance group for further advice.

Involvement of friends, family and other support networks in the review

In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences.

The review panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'-based violence.

Benefits of involving family, friends and colleagues

The benefits include assisting the family with the healing process which links in with the objectives of the new National Homicide Service - supporting victims for as long as they need after homicide. For example, a review may allow them to disclose information in private, which may not be published. A family would not be able to achieve this in an inquest, which is in the public domain.

Other benefits are:

- helping families satisfy the often-expressed need to contribute to the prevention of other domestic homicides
- obtaining relevant information held by family members, friends and colleagues which is not recorded in official records
- revealing different perspectives of the case, enabling agencies to improve service design and processes
- allowing the review panel to get a more complete view of the victim's life and see the homicide through the eyes of the victim and those left behind - this approach can help the panel understand the decisions and choices the victim made

Considerations

The review panel should be aware of the potential sensitivities and need for confidentiality when meeting with members of informal support networks during the review and all such meetings should be recorded.

Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide.

The review panel should also access other networks that victims may have disclosed to, for example, employers, health professionals or their local voluntary and community sector (VCS) agencies.

There are information leaflets explaining the domestic homicide review process to family, friends and support networks of the victim.

- Domestic homicide review: leaflet for family
- Domestic homicide review: leaflet for friends
- Domestic homicide review: leaflet for employers and colleagues

Involving friends, family and other supports in the review: actions

When meeting with friends, family members and others the panel should:

- communicate through a designated advocate who has, where possible, an existing working relationship with the family eg a voluntary and community sector (VCS) representative.
- make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other ongoing processes ie post mortems, criminal investigations.
- ensure initial contact is made in person and deliver the relevant information letter and leaflet.
- ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- explain clearly how the information disclosed will be used and whether this information will be published.
- explain how their information has assisted the review and how it may help other domestic violence victims.
- a completed version of the review should be given to the family before a final review is sent to the Home Office. This allows other findings and recommendations to be considered, and makes it possible to record any areas of disagreement.
- maintain reasonable contact with the family, even if they decline involvement in the review process. It will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication ie media attention and renewed interest in the homicide.

Ongoing risk

The review panel should also be mindful that the perpetrator or members of the perpetrator's family might in some cases pose an ongoing risk of violence to the victim's family or friends.

If the review panel is concerned that there may be a risk of imminent physical harm to any known individual, they should contact the police immediately so that steps can be taken to secure protection.

Particular consideration should be given to reviews where 'honour'-based violence is suspected. Extra caution will need to be taken around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the perpetrators.

Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area, for example, a specialist black and minority ethnic (BME) women's organisation.

Individual management reviews (IMR)

The aim of the individual management review (IMR) is to:

- allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made
- identify how those changes will be brought about
- identify examples of good practice within agencies

Each agency should secure its records relating to the case and draw up a chronology of their involvement with the victim, perpetrator or their families. Each agency should then carry out an IMR of its involvement with the victim or perpetrator.

Professionals outside of the IMR process (eg GPs) should contribute reports of their involvement with the victim or perpetrator to the chair of the review panel. Those conducting IMRs should not have been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR.

IMR reports should be quality assured by the senior manager in the organisation who has commissioned the report. This senior manager will be responsible for ensuring that any recommendations from both the IMR and, where appropriate, the overview report are acted on appropriately.

Review panel action on receiving an overview report

On completion of the overview report the review panel should:

- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report
- ensure that the overview report is of a high standard and is written in line with the guidance

Overview report action plan

The review panel should make sure that relevant recommendations in the overview report are put into an action plan, which is agreed at senior level by each of the participating organisations.

The action plan should set out who will do what, by when, with what intended outcome. The action plan should set out how improvements in practice and systems will be monitored and reviewed.

Once agreed, the review panel should provide a copy of the overview report, executive summary and the action plan to the chair of the CSP.

Community safety partnership (CSP) action on receiving the overview report

The community safety partnerships (CSP) should:

1. Agree the content of the overview report, executive summary and action plan, ensuring that the documents are fully anonymised apart from including the names of the review panel chair and members.
2. Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.
3. Provide a copy of the overview report, the executive summary and the action plan to the Home Office quality assurance group. This should be via email to DHREnquiries@homeoffice.gsi.gov.uk

The document should not be published until clearance has been received from the Home Office quality assurance group. On receiving clearance from the Home Office quality assurance group, the CSP should:

1. Provide a copy of the overview report, executive summary and action plan to the senior manager of each participating agency.
2. Publish an electronic copy of the overview report and executive summary on the local CSP web page.
3. Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) action plan.
4. Formally conclude the review when the action plan has been implemented and include an audit process.

Learning lessons and good practice

Domestic homicide reviews are an important source of information to inform national and local policy and practice. All agencies involved have a responsibility to identify and share common themes and trends across review reports, and act on any lessons identified to improve practice.

It is important to draw out key findings of domestic homicide reviews and their implications for policy and practice.

The following may assist in achieving maximum benefit from the review process:

- as far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.
- consider what type and level of information needs to be disseminated, how and to whom, in the light of the review. Be prepared to communicate both examples of good practice and areas where change is required.
- subsequent learning should be spread to the local multi-agency risk assessment conference (MARAC) and the local domestic violence forum or similar, the local safeguarding children board and commissioners of services.
- include the learning into local and regional training programmes.

- the community safety partnership (CSP) will put in place a means of monitoring and auditing the actions against recommendations and intended outcomes.
- set up a culture of learning lessons by having a standing agenda item for domestic homicide reviews on the meetings of community safety partnerships and domestic violence forums or similar groups.

Quality assurance

Quality assurance for completed domestic homicide reviews rests with an expert group made up of statutory and voluntary agencies and managed by the Home Office.

All completed overview reports, executive summaries and action plans should be sent to the Home Office. They will be assessed against the guidance by an exert group. The group meet on a quarterly basis to assess report standards as well as identifying good and poor practice and training needs.

Send reports to: DHREnquiries@homeoffice.gsi.gov.uk

Where reviews are assessed as inadequate, a summary of findings is sent to the community safety partnership (CSP) chair who is responsible for ensuring the areas of concern are revisited and amended by the review panel.

The Home Office quality assurance group is also responsible for:

- disseminating lessons learned at a national level and effective practice
- identifying serious failings and common themes
- communicating with the media to raise awareness of the positive work of the statutory and voluntary agencies with domestic violence victims and perpetrators so that attention is not focused disproportionately on tragedies
- communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies
- providing central storage for DHRs to allow for clear auditing of review documentation and quick retrieval if required
- requesting updates from local areas on actions taken following a review
- reviewing decisions by CSPs not to undertake a DHR
- recommending national training needs and working across government to ensure existing training is highlighted
- recommending service needs to commissioners

You've now completed module 1.

Module 2 only needs to be completed by the review panel chairperson, although this information may also be useful to other practitioners involved in the review process.

Appendix 8: LeDeR programme core principles and values:

The LeDeR Programme must effect change and make an identifiable difference to the lives of people with learning disabilities and their families.

We value the on-going contribution of people with learning disabilities and their families to all aspects of our work and see this as central to the development and delivery of everything we do.

We take a holistic perspective looking at the circumstances leading to deaths of people with learning disabilities and don't prioritise any one source of information over any other.

We strive to ensure that reviews of deaths lead to reflective learning which will result in improved health and social care service delivery.

The key principles of communication, cooperation and independence will be upheld when working alongside other investigation or review processes.

Our aim is to embed reviews of deaths of people with learning disabilities into local structures to ensure their continuation.

Reviews of deaths:

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities aged 4 years and over, irrespective of whether the death was expected or not, the cause of death or the place of death. This will enable them to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

In order to prepare for this, the LeDeR programme has:

- Held a national consultation about the core information that should be collected about each person with learning disabilities who dies (completed in October 2016). A summary of survey responses received by the end of September 2015 can be found here consultation reponse (PDF, 244kB)

- Built a secure web-based platform to support the review process, including handling notifications of deaths and supporting the work of local reviewers
- Obtained the necessary statutory approvals and permissions for the LeDeR Programme

- Developed and is now piloting a process for local reviews of deaths, including developing protocols, guidance and training materials
- Learned from the first pilot site in NE and Cumbria about the benefits and challenges of using the LeDeR process to conduct local reviews of deaths of people with learning disabilities, prior to wider roll-out of reviews across England.

A summary document providing guidance about reviewing deaths of people with learning disabilities can be found here Guidance for the conduct of local reviews (PDF, 743kB)

What will local reviews of deaths consist of?

- An initial review of each death
- A fuller multiagency review of deaths that meet the criteria for this
- Expert panel scrutiny of the fuller multiagency review of deaths that are subject to priority themed review. Initially, this will be deaths of young people aged 18-24 years and people from Black and Minority Ethnic Communities.

- An action planning process that picks up on learning and recommendations identified during the review process and translates these into improvements in the delivery of health and social care for people with learning disabilities.

You can find more detailed information on our website about reviewing a death of a person with learning disabilities.

For reassurance about our permission to share confidential information about people who have died, see the approval letter from the Confidentiality Advisory Group confirming S251 approval and the most recent amendment to the approval letter:

Confidentiality Advisory Group approval (PDF, 144kB)

CAG Amendment Outcome (PDF, 210kB)

Initial Review of a death:

For each death there is an initial review. The purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a multiagency review of the death that would contribute to improving practice.

The initial review involves inviting somebody who knew the person well (e.g. a family member, paid carer) to contribute their views about the sequence of events leading to death, limited case note review and the completion of a standard questionnaire. The local reviewer will write a 'pen portrait' about the person who has died and complete a timeline of events leading to their death.

At the completion of the initial review the local reviewer will decide if a full multi agency review is required or not. If not, the local reviewer will complete an action plan detailing any learning points or recommendations that should be considered. If there are any areas of concern in relation to the care of the person who has died, or if any further learning could be gained from a multiagency review of the death that would contribute to improving practice, the death will be subject to multiagency review Multiagency Review of a death If there are any areas of concern identified at the initial assessment, or if it is felt that a fuller review could lead to improved practice, a multiagency review takes place. Some other deaths will automatically have a multiagency review, irrespective of the initial assessment of the death; these are deaths that are subject to priority themed review.

A multiagency review of a death involves the range of agencies that had been supporting the individual who had died, and considers three phases of care:

a) Initial diagnosis and management of the condition
b) Ongoing management of the condition from initial diagnosis to critical illness
c) Management and care received during final illness

Agencies are requested to contribute to the 'pen portrait' and timeline established at the initial assessment, then to return these documents to the local reviewer with a copy of any relevant notes.

Once the information has been collated, a multiagency meeting is held to identify and discuss a number of issues:

- Any good practice that has been identified in relation to the person's death
- If any potentially avoidable contributory factors to the death have been identified
- If, on balance, there were any aspects of care and support that, had they been identified and addressed, may have changed the outcome

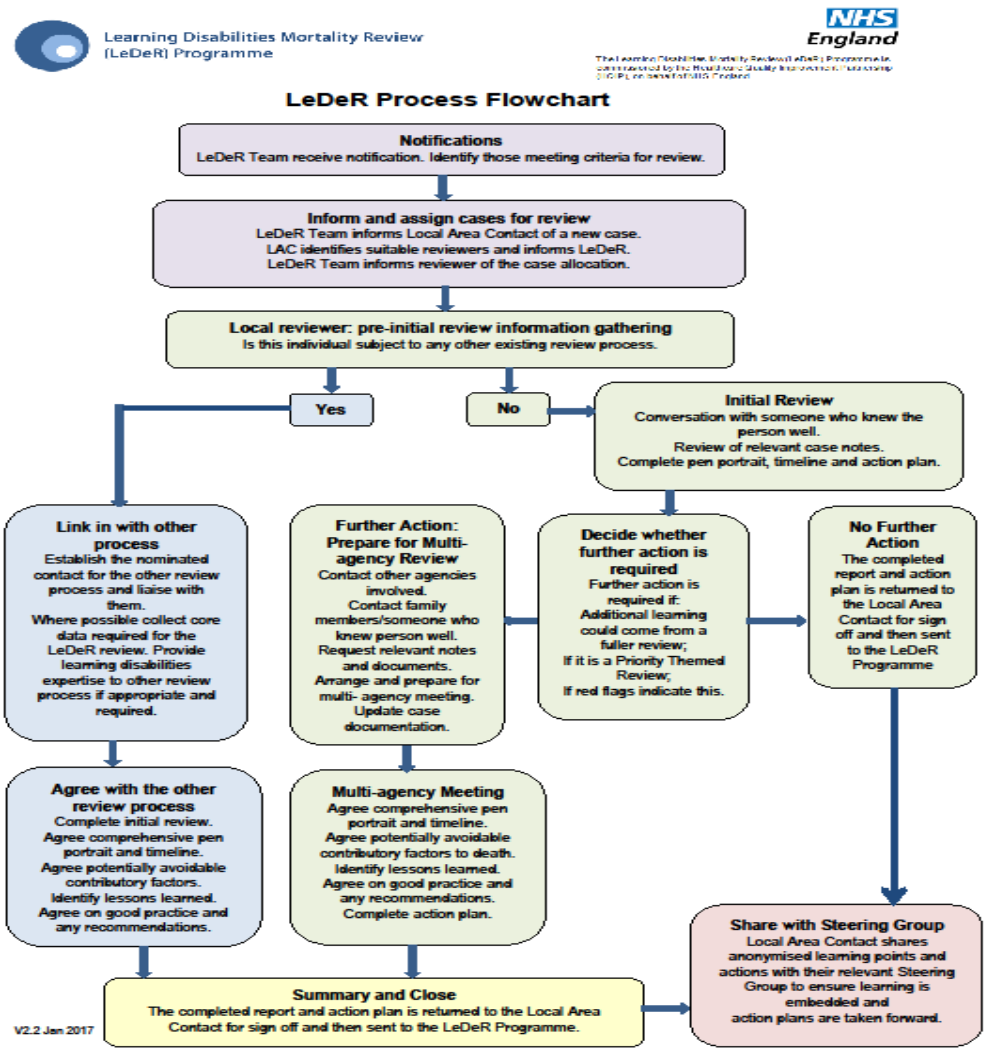
- If there have been any lessons learned as a result of the review of the death
- If there should be any changes made to local practices as a result of the findings of the review
- If there are any wider recommendations that should be made.

At the completion of the multiagency review, the local reviewer will complete a multiagency review report and an action plan detailing any learning points or recommendations that should be considered. The action plan will be reviewed to ensure that it is translated into improvements in the delivery of health and social care for people with learning disabilities.

Action planning Process:

At the completion of each initial assessment or multiagency review, an action plan will be completed by the local reviewer. This will detail any actions to be taken that may improve the provision of care for people with learning disabilities or others. The purpose of the plan is to clarify the actions to be taken, by whom, and to identify a clear line of responsibility and timeframe for the actions. Action plans will be reviewed by each local area contact, and at regional level, anonymised action plans will be reviewed by the steering group. Recurrent themes and significant issues will be identified and addressed at local and regional levels.

The LeDeR Programme will monitor completed action plans to ensure that practice improvements take place as a result of the local reviews of deaths of people with learning disabilities.



Feedback Questions	Comments
1. SAR Unique Identifier:	
2. How was the SAR referred to the Board?	
3. How long between the SAR Notification and SAR Review commencement was there?	
4. Were there any delays? If so, what were they? Be specific.	
5. Was the Review externally commissioned? If so, by whom, how long did it take to source them? If not, who undertook the SAR and why were they chosen?	
6. How many agencies were involved? Were there any delays or matters arising with regards to the SAR? If so, be specific. Have you notified the senior managers of the difficulties? If so, whom and what was said.	
7. Was there any specific learning for the Board and its partners?	
Sent to the Chair/Vice Chair on: **Completed by:**	