Bolton Safeguarding

Adults Board

Learning Lessons
Safeguarding Adults Review

Policy & Practice Guide

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1. Introduction

1.1 The Care Act 2014 is a long awaited landmark for Adult Social Care, bringing together the best of social care legislation and national policy that has developed over decades of local government practice. This legislation supersedes any existing social care legislation and as such replaces the document ‘No Secrets’ issued by DoH under section 7 of the Local Authority Social Services Act 1970, which gave guidance on developing and implementing multi-agency policies and procedures to protect adults from abuse.

1.2 Section 6 of the Care Act states that all agencies should co-operate with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

1.3 The Care Act 2014 states that all Safeguarding Adult Boards (SABS) must arrange a Safeguarding Adults Review, (previously referred to as a Serious Case Review (SCR) in certain circumstances as listed in Section 2 of this policy.

1.4 This policy and practice guide has replaced the term ‘vulnerable adult’ with the term ‘adult at risk’ at this is the terminology used by the Care Act 2014. This has been shortened in places to just using the word ‘adult’.

1.5 Under the definition of the Care Act 2014 an ‘adult at risk’ is anyone who is over 18 who:
- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and,
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

1.6 Safeguarding Adults Reviews are not enquires into how an adult at risk dies or who is culpable; that is a matter for safeguarding enquires, Coroners or Criminal Courts to determine, as appropriate. It is usual for a SAR to be conducted on conclusion of a Safeguarding Enquiry.

2. Purpose of a Safeguarding Adults Review

2.1. The purpose of a Safeguarding Adults Review is to:
- Establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk.
- Identify how lessons learned will be acted upon and what is expected to change as a result.
- Disseminate lessons learned, promoting effective practice and improvement action to minimise the risk of future deaths or serious harm occurring.
2.2. Safeguarding Adults Reviews are not to apportion blame, or to further investigate the death or injury. The following principles should be applied by SABs and their partner agencies to all reviews:

- There should be a culture of continuous learning across all organisations that work together to safeguard and promote the wellbeing and empowerment of adults.
- The approach taken to reviews should be proportionate, according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be held by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. (See 5.8 for further guidance).
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. The reviews should encourage honesty, transparency and sharing information to obtain maximum benefit for them.
- Families should be invited to contribute to reviews. Early discussions need to take place with the adult, family and friends to agree how they wish to be involved ensuring openness and engagement in the process from an early stage. Consideration should be given to offering the adult or the families an advocate to support them/advocate of their behalf during this process.

3. Criteria for a Safeguarding Adults Review (SAR)

3.1. A Safeguarding Adults Review is not restricted to occasions where the safeguarding procedures have been followed, and can be applied where this has not been the case. However, if a safeguarding enquiry has been undertaken then the SAR will usually take place upon conclusion of this safeguarding procedure.

The criteria used to determine if a case should be considered as a SAR is described below:

- An adult at risk has died as a result of abuse, neglect, or harassment, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.

- A Domestic Homicide Review (DHR) must be considered when the death of an adult at risk appears to have resulted from violence, abuse, neglect by a person to whom s/he was:
  - Related or who was or had been in an intimate relationship;
  - Living in the same household.
A DHR will be overseen by the Community Safety Partnership in consultation with the SAB. (Referrals are made by the police to the Chair of the Community Safety Partnership who then considers the case and determine if it meets the criteria for such a review).
• SABs must also arrange a SAR if an adult in its area, with needs for care and support, has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

• An adult at risk is confirmed or suspected of being abused or neglected and the case is likely to be of public concern. This may include incidents of serious abuse or neglect within an institution, or agency providing services to adults at risk or where multiple abusers or victims are identified.

3.2 The decision as to whether the criteria for a Safeguarding Adult Review is met will be determined by the Lessons Learned Panel who will make a recommendation to the Chair and BSAB. (Please refer to Appendix 5 for the membership and terms of reference for this subgroup).

If HM Coroner contacts the BSAB about any of these situations, the Lessons Learned subgroup will give careful consideration to recommending that a SAR be conducted.

4. Coroner

4.1 Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths, sudden deaths of unknown cause, deaths in custody, and adults subject to Deprivation of Liberty Safeguards. 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 there is an obvious and serious failing by one or more organisations.
• Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
• Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home); or,
• Deaths that fall outside the requirement to hold an inquest but follow-up enquires/actions are identified by the Coroner or his or her officers.

4.2 The SAR report must be made available to the Court Proceedings in the Coroners Court if requested.

5. The Decision to Conduct a Safeguarding Adults Review and recommending the Overall Approach. (Refer to Decision-Making Flowchart 5.12)

5.1 Any professional can make a referral for a Safeguarding Adult Review and referrals may be made by the Coroner, MPs and Elected Members. Staff will usually find it helpful to discuss their concerns with their agencies
representative on the Safeguarding Adults Board prior to making a referral. Other parties, such as agencies who are not members of the Safeguarding Board, family members, carers or members of the public should raise their concerns with the member agency of the Safeguarding Adults Board they have direct contact with.

The referral should be made using the form on Appendix 1 and should be sent directly to the Chair of the Safeguarding Adult Board.

5.2 The Learning Lessons Sub-group will be convened on receipt of a referral and will decide whether to seek scoping information from relevant agencies or whether an alternative response is required. The sub-group will be made up of membership agencies on the SAB and will co-opt other agencies as requested on a case by case basis to assist the decision making.

5.3 If the Learning Lessons Sub-group considers that a scoping enquiry to all relevant agencies would assist in deciding how to progress the referral, the Safeguarding Adult Board Manager will send out a request to all relevant agencies asking for a summary of their involvement with the adult at risk and the person(s) / Organisation(s) Alleged Responsible to have Caused Harm or Neglect. This should be returned within a two week period.

5.4 Once the summaries from the relevant agencies have been received, the Safeguarding Adult Board Manager will collate all the relevant information and provide a copy of this to all members of the sub-group to inform their decision about how to progress the referral that is whether it does or does not meet the criteria for a SAR. Where it does not, then an alternative approach may be considered to assist with lessons learnt.

5.5 The Safeguarding Adult Board Manager or the Chair of the Lessons Learned Sub-group will also advise the Chair of the Bolton SAB of the recommendation.

5.6 The Learning Lessons Sub-group should aim for a consensus, not a majority view in its recommendation; the nature of a Safeguarding Adults Review is that it is multi-agency and therefore it is important that the multi-agency sub-group agrees the way forward as a partnership.

5.7 The decision to conduct a Safeguarding Adult Review will only be made by the Bolton SAB. The decision will be made on the recommendation of the Lessons Learned Sub-group.

5.8 The Lessons Learned sub-group should consider and make a recommendation as to the process to undertake a SAR based on the specific characteristics of the case. Either the Sub-group or the Review Panel will recommend:

- Which agencies should be asked to participate in the Safeguarding Adults Review?
• Whether the agencies concerned are required to secure their files.
• Which methodology should be used to facilitate learning in this case?
• The Terms of Reference for the Safeguarding Adult Review (including the time-span of the review).
• The required output from the Safeguarding Adult Review (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 a Bolton SAB member agency.
• Identify a suitable person/agency to lead the review, who is independent from the SAB and the agencies involved in the case and is a sufficiently skilled and experienced to carry out this role.

5.10 If the Bolton Safeguarding Adult Board agrees that a SAR is required the Board will instruct the Chair of the Lessons Learned Panel to:

• Notify the referring agency and constituent agencies in writing within 72 hours of the decision being reached.
• Establish a review panel and brief the lead reviewer/chair of the case.
• Consult with Greater Manchester Police to determine whether the case fits the criteria for a Domestic Homicide Review (if yes please refer to the Bolton Domestic Homicide Review Protocol).
• Request agencies (if not already done so) to secure records and complete and return a summary of involvement. This will be done via the Bolton SAB members who will ensure that a Senior Nominated Officer is agreed to engage with the process.

5.10 Partner agencies upon receiving notification that a SAR is going to take place should ensure that:

• All relevant information and case records are promptly secured;
• A Senior Nominated Officer takes possession of the file or where the case record is electronic, immediately prints off the case records.
• Where the case record is not electronic, all information in the record should be photocopied and the photocopy returned to the relevant worker to enable case work to continue.
• Files transferred within or between agencies should be delivered in person.

5.11 Recommendations to the Independent Chair of the Bolton SAB

• In addition to recommending whether or not a review should take place following receipt of a referral, the Lessons Learned Sub-group will make recommendations to the Chair of the Bolton SAB about:

  i. Any urgent actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review.
ii. The overall approach to the Safeguarding Adults Review (See Section 5). Where this has been delegated to a Review Panel, the Sub-group Chair will explain this to the Chair.

5.12 Decision-Making Flowchart

SAR Referral Received by the Chair

Yes

Lessons Learned Sub-group considers referral against the criteria
SAR Criteria met?

Yes

Scoping Enquiry Disseminated

Yes

Lessons Learned Sub-group reviews information form
Scoping Enquiry
SAR Criteria Met

Yes

Review Panel propose:
- Terms of Reference
- Methodology
- Required Outputs
- Security of Files

Yes

Bolton SAB Chair accepts
Lessons Learned Sub-group recommendations?

Yes

Bolton SAB informed
Referrers informed

SAR Commissioned and panel established

No

Criteria not met. Recommendations made to address any remaining concerns. Referral closed.

Bolton SAB inform the Referrer
5.13 If a request to undertake a Safeguarding Adults Review is declined

- If a request is being declined, the reasons will be recorded in writing by the Chair of the Lessons Learned Panel and shared with the referrer and the next full meeting of the Adult Safeguarding Board as an agenda item. The Chair of the Lessons Learned Panel will endeavor to inform the referrer within 28 days of the request being received.

- In such circumstances, the Chair of the Learning Lessons subgroup or the Chair of the Safeguarding Board could request a service to conduct an alternative course of action:

  - **Internal Management Review** – 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.
    A template for an internal management review (IMR) is available at Appendix 2

  - **File audit** – this will require a manager to audit the case file of the individual in order to determine if procedures were followed, and if they were, that there is documented evidence substantiating the decision making of this agency, throughout their involvement with the individual.

  - **Reflective Practice sessions with relevant professionals** – these sessions would be held with the workers directly involved with the individual, and will allow the practitioners to reflect directly on their own practice with a view to identifying lessons learned within a reflective and therapeutic environment. This could be undertaken collectively or on an individual basis.

  - **Multi-agency Workshop** – this would involve practitioners and middle managers who may or may not have been involved directly in the case. Workers may be asked to consider specific questions whilst reviewing the chronologies and summaries of the individual agencies involvement in the case.

  - **No further action**

    The findings/lessons learned from any of the above will be presented to the Bolton’s SAB, who will determine how learning will be shared and acted upon within the partnership.
6. Safeguarding Adults Reviews – Methodologies and Recommendations to the Bolton SAB

6.1 Methodologies

- The Bolton SAB 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)\(^1\) 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 Bolton SAB fully endorses this approach and the Lessons Learned Sub-group is asked to consider various different ways of enabling learning when recommending a Safeguarding Adults Review. The Bolton SAB 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. All Safeguarding Adults Reviews conducted on behalf of the Bolton SAB are of equitable significance and value. Research evaluating adult safeguarding Serious Case Reviews\(^2\) in London notes, ‘Robust leadership is needed within and between all partner agencies, to enable cultures that embrace reflection, learning and change. Chief Officers, management boards, local politicians and Safeguarding Adults Boards all have a role to play in setting expectations and driving this agenda forward’. The Bolton SAB supports this view.

- Possible methodologies for Safeguarding Adults Reviews are set out below. This list is not exhaustive and the Lessons Learned Sub-group will use its collective experience and knowledge to recommend the most appropriate learning method of the case under consideration.

- All of those participating in a Safeguarding Adults Review will be provided with training to support them in carrying out that role. 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\(^3\). 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.

6.2 Significant Event Analysis/Audit

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\(^1\) Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services, ADASS, March 2013

\(^2\) London Joint Improvement Programme: Learning from Serious Case Reviews on a Pan London Basis, Sue Bestjan, March 2012

• 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. Significant Event Analysis or Audit has been used for many years in the NHS to analyse a significant event in, ‘a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements’.\(^4\)

• The process followed in a Significant Event Analysis or Audit is as follows:\(^5\)

  - 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?

6.3 Systems Approach

• The ‘systems’ model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow\(^6\) 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\(^7\) 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:

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\(^5\) Adapted from: A Quick Guide to Conducting a Significant Event Audit, National Patient Safety Agency, October 2008

\(^6\) Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Sheila Fish, Eileen Munro and Sue Bairstow, SCIE, January 2012

\(^7\) Munro Review of Child Protection, Department for Education, May 2011
i. Scoping of review / terms of reference, identification of key agencies/personnel, roles, time frames (completion, span of person’s history), specific areas of focus/exploration.

ii. Appointment of facilitator and overview report author.

iii. Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies.

iv. Material circulated to attendees of learning event, anticipated attendees to include: members from the Safeguarding Adults Board, frontline staff /line managers, agency report authors, other co-opted experts (where identified), facilitator and/or overview report author.

v. Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt.

vi. Consolidation into an overview report, with: analysis of key issues, lessons learned and recommendations.

vii. Event to consider first draft of the overview report and action plan.

viii. Final overview report presented to Safeguarding Adults Board, agree dissemination of learning and monitoring of implementation.

ix. Follow up event to consider action plan recommendations.

x. On-going monitoring via the Safeguarding Adults Board.

6.4 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.

- A template for an Individual Management Review (IMR) and a checklist for a good IMR are available at Appendix 2.

- 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.

6.5 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. 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.

6.6 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 is 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. However, as Dr Munro and colleagues acknowledged⁸, there is a risk that they can be time consuming, resource intensive conclude too late, ensuring current and timely learning and change. For those reasons, the Lessons Learned Sub-group will give very careful consideration to any added value achieved through this approach.

6.7 The findings/lessons learned from any of the above will be presented to the Bolton’s SAB, who will determine how learning will be shared and acted upon within the partnership.

7. Timescales

7.1. Individual Management Reviews should be completed and reports submitted within three months of the initial decision to convene a SAR – unless agreed otherwise with the SAR chair.

7.2. The SAR should always be completed within six months of the initial decision and endorsement by BSAB chair.

7.3. The complexity of a case may not become apparent until the review is in progress. As soon as it becomes apparent that it cannot be completed within six months, there should be a discussion with the

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⁸ Learning together to safeguard children: developing a multi-agency systems approach for case reviews, Sheila Fish, Eileen Munro and Sue Bairstow, SCIE, January 2012
SAR Chair who will alert the BSAB Chair to agree a timescale for completion.

7.4. Where criminal proceedings are underway or under consideration, the SAR Chair should discuss with the relevant criminal justice agencies how the review process should take account of such proceedings and when findings or partial findings from the SAR can be actioned and published.

7.5. In some cases it may not be possible to complete a review until after criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented.

7.6. Findings from any other review processes, i.e. coroner, homicide review etc. should where possible be referenced and considered as part of the SAR process.

8. Roles and Responsibilities

8.1 Director of Children and Adult Services

- The Director of Adult Social Services has the statutory role in relation to safeguarding adults in Bolton and therefore this post holder is ultimately responsible for all Safeguarding Adults Reviews.

- Where a Safeguarding Adults Review has a report of its findings, this will be approved by the Director of Children and Adult Social Services, together in consultation with the SAB and the Chair of the Lessons Learned Sub-group.

- Where relevant, Bolton Council will be responsible for holding a joint Bolton SAB press statement / release as necessary on behalf of the Board. The Director of Adult Social Services will agree this statement / release in consultation with the Board and the Chair of the Lessons Learned Sub-group. Senior responsible managers and Board members of any agencies that have issues that are particularly sensitive within the report will also be involved in that discussion. The Director of Children and Adult Social Services will receive a recommendation from the Bolton SAB to accept the conclusion of a Safeguarding Adults Review, including the content of any report and multi-agency action plan.

8.2 The Bolton Safeguarding Adults Board (BSAB)

- The BSAB will meet to consider the recommendations of the Lessons Learned Sub-group to hold a SAR and determine if the case meets the criteria and if so determine which methodology is to be used (Refer to Section 6). If the Board endorses the recommendation they will instruct the Lessons Learned Sub-group to convene and appoint a Safeguarding Review Panel to oversee the process.

- Members of the Bolton SAB will consult regularly with the staff from their agency who are participating in Safeguarding Adults Reviews, to ensure
they are informed but also can provide support and guidance. Bolton SAB 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 Bolton SAB is responsible for recommending to the Director of Children and Adult Social Services approval of all Safeguarding Adults Review reports and action plans. Bolton SAB members are responsible for ensuring their organisation’s actions within Safeguarding Adults Reviews multi-agency action plans are achieved.

- When compiling and preparing to publish reports the Bolton SAB 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 Bolton SAB 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.

8.3 Bolton SAB Lessons Learned Sub-group

- This Panel is a standing group of Bolton Safeguarding Adults Board and membership is drawn from partner organisations, Panel has flexibility to co-opt other relevant representation as and when appropriate. Appendix 3 provides the Terms of Reference.

- Panel members, including the Chair, should not have had any previous involvement in the direct management of the case. The Panel will be chaired by a senior manager from Adult Services or NHS Trusts.

- The Panel will be convened to determine and confirm whether the Safeguarding Adult Review criteria have been met. This meeting should be held within one month of the notification being sent out to partner agencies.

- The Panel can meet and propose that the Safeguarding Adult Review Criteria are met and that it is necessary/desirable to learn lessons even before the investigations into the circumstances of the death/serious injury are completed, or investigation outcomes are known.

- The Lessons Learned Sub-group will notify the Chair of the SAB of the recommendation to conduct the SAR and the proposed process that should be followed.

- The Panel Chair will need to discuss with relevant criminal justice agencies e.g. Police, Coroner how any proposed review process should take account of on-going proceedings, and determine if a Domestic Homicide Review is taking place, if a SAR needed. If a SAR is required the Panel Chair will need to determine how this will differ from the Domestic Homicide Review.

- Organisations should ensure they prepare all relevant information in a timely manner for the meeting. This includes preparing a chronology and providing a brief synopsis of their organisations involvement.
• An overview of each Safeguarding Adults Review will be reported to each meeting of the Bolton SAB.

8.4 Safeguarding Adults Review Chair

• Where the Safeguarding Adults Review requires a chair, this will role will be undertaken by either a member of the Lessons Learned Sub-group, or another experienced individual who is nominated 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 Lessons Learned Sub-group and will need to keep that person regularly informed of the progress of the Review in order that the Bolton SAB 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 Bolton SAB 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 for ensuring that all relevant interested parties are kept informed of progress of the Safeguarding Adults Review as appropriate.

• 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 Chair of the Bolton SAB for consideration and recommendation to the Board.

8.5 Independent Author

• Where an Independent Author is required in a Review will be appointed from the Bolton SAB approved pool of authors to write an independent Safeguarding Adults Review Report on behalf of the Bolton SAB 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 provide the Bolton SAB with positive learning that will enable it to improve services and safeguarding in the Borough of Bolton.

• The Independent Author will not communicate directly with Adults(s) at Risk, Person(s) or Organisation(s), family members or significant others; this is the role of the Lessons Learned Sub-group.
8.6 Safeguarding Adults Review Panel Members

- Members of a Safeguarding Adults Review panel will be nominated by their Bolton SAB 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 Lessons Learned Sub-group, the Review Panel will recommend the detail of the approach to the review, including, timescales, terms of reference, methodology etc. (See 5.8)

- Members of the Safeguarding Adults Review Panel will feedback to their agency’s Bolton SAB member on progress and key issues emerging from the Review.

8.7 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 Bolton SAB values the importance of their views and also recognises that the process can be difficult. As such, the Lessons Learned 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 the views of any of the above 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 Bolton SAB and the Director of Children and Adult Social Services, the Chair of the Board and the Chair of the Lessons Learned Sub-group will offer to meet with these people to explain the Review conclusions.
9. Governance

- 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.

9.1 Safeguarding Adults Review Reports and Action Plans

- All reports of Safeguarding Adults Reviews are owned by the Bolton SAB and held securely by the Safeguarding Adults Board Manager. Reports and action plans are only final when accepted by Bolton SAB and agreed by the Director of Children and Adult Social Services.

- 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.
  - Be suitable for publication without needing to be amended or redacted.

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

- The Bolton SAB is responsible for recommending approval of all Safeguarding Adults review Reports and Action Plans. The Lessons Learned Sub-group is responsible for monitoring and confirming completion of all Safeguarding Adults Review action plans.

- The Director of Children and Adult Social Services will receive a recommendation from the Bolton SAB to accept the conclusion of a Safeguarding Adults Review, including the content of any final report and multi-agency action plan. This will be recorded within the minutes of the following Bolton SAB meeting.

- 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 Lessons Learned Sub-group. Any failure to complete actions will be escalated to the Chair of the Board with the knowledge of the relevant Bolton SAB Board member. Where this relates to organisation that is commissioned by the Bolton SAB member, this will also be raised with the commissioner and regulator. The BSAB will monitor progress of the action plan at agreed intervals.

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

- Consideration will be given by the Board as to whether or not a completed Safeguarding Adults Review Report and/or action plan should be shared with Bolton Children’s Safeguarding Board if there is relevant learning that crosses over into Children's Services.

**9.2 Review of Action Plans and Recommendations**

- The Bolton SAB will monitor progress of action plans at agreed intervals. The action plan will remain on the Safeguarding Adult Board agenda until such time that all recommendations have been implemented.

- **All Safeguarding** Adult Reviews conducted within the year should be referenced within the Safeguarding Adult Board Annual Report along with relevant service improvements.
Appendix 1: Safeguarding Adult Review Notification Form

Please send the completed form securely to:

Email:

By post:

Enquiries:

REFERRER DETAILS

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGENCY &amp; DESIGNATION</th>
<th>CONTACT DETAILS – Address, telephone number and e-mail address</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Date of referral:

Cases which meet one or more of the following criteria should be referred for 12

The criteria used to determine if a case should be considered as a SAR is described below:

- An adult at risk has died as a result of abuse, neglect, or harassment, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.

- SABs must also arrange a SAR if an adult in its area, with needs for care and support, has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

- An adult at risk is confirmed or suspected of being abused or neglected and the case is likely to be of public concern. This may include incidents of serious abuse or neglect within an institution, or agency providing services to adults at risk or where multiple abusers or victims are identified.
**Adult DETAILS** – this relates to the adult who is the subject of the serious incident

<table>
<thead>
<tr>
<th>Name of Adult</th>
<th>Date of Birth</th>
<th>Date of Death or Serious Incident</th>
<th>Home address</th>
<th>Gender</th>
<th>Ethnic Origin</th>
<th>Faith/Religion</th>
<th>Disability</th>
</tr>
</thead>
</table>

**Level of involvement at time of Incident:-** *(please select one option)*
- Single agency involvement
- More than one agency involved
- In receipt of a care package
- Safeguarding enquiry/safeguarding plan in place
- In receipt of 24 hour care

<table>
<thead>
<tr>
<th>Location of incident if different from Home Address</th>
<th>Are there any children safeguarding concerns and have these been shared and with whom?</th>
</tr>
</thead>
</table>

**DETAILS of Significant Others – Relatives, Next of kin, Advocate, IMCA, Power of Attorney**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to adult</th>
<th>Date of birth</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
### 3. Agencies known to be involved with the case (please specify)

<table>
<thead>
<tr>
<th>Adult Services</th>
<th>Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>Drug and Alcohol Services</td>
</tr>
<tr>
<td>G.P</td>
<td>Health Services</td>
</tr>
<tr>
<td>Housing</td>
<td>Provider Agency</td>
</tr>
<tr>
<td>Others (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Reason for notification (more than one box may be ticked)

An adult at risk has died as a result of abuse, neglect, or harassment, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult in its area, with needs for care and support, has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

An adult at risk is confirmed or suspected of being abused or neglected and the case is likely to be of public concern. This may include incidents of serious abuse or neglect within an institution, or agency providing services to adults at risk or where multiple abusers or victims are identified.

### 5. Characteristics of Case (Please tick all applicable factors)

<table>
<thead>
<tr>
<th>Domestic abuse</th>
<th>Alcohol abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Drug abuse</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Discriminatory Abuse</td>
</tr>
<tr>
<td>Self-neglect</td>
<td>Neglect or acts of omission</td>
</tr>
<tr>
<td>Emotional/psychological abuse</td>
<td>Modern slavery</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Financial abuse</td>
</tr>
</tbody>
</table>

### 6. Case Outline

Please give a summary of the circumstances of this case and explain why you feel this case should be considered for a Safeguarding Adult Review.
For Office Use:
This section will be used to record Bolton’s Lessons Learned Sub-group of the screening decision of BSAB

<table>
<thead>
<tr>
<th>INITIAL CASE SCREENING OUTCOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult Review criteria <strong>highly likely</strong> to be met</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adult Review criteria <strong>possibly</strong> met</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adult Review criteria not met but possibility of further review</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adult Review criteria not met and no requirement for further action</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CASE TRACKING INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Screening</td>
<td></td>
</tr>
<tr>
<td>Carefirst/NHS No:</td>
<td></td>
</tr>
<tr>
<td>Date form completed</td>
<td></td>
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<tr>
<td>Date submitted to BSAB Chair</td>
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</tbody>
</table>
Appendix 2

Individual Management Review - Outline Format for Report

What was our involvement with this adult at risk?
Construct a comprehensive chronology of involvement by the organisation
and/or professional(s) in contact with the adult over the period of time set out
in the Review’s terms of reference. Summarise decisions reached, services
offered and any other action taken.

Analysis of involvement
Consider the events that occurred, decisions made and actions that were or
were not taken. Where judgements were made or actions taken, which
indicate that practice could be improved, consider specifically the following:

- Were practitioners able to recognise indicators of possible abuse or risk
  of significant harm?
- Were these concerns shared with appropriate others?
- Were these concerns acted on appropriately?
- Did the organisation have procedures in place for safeguarding adults
  at risk?
- Were assessments and decisions reached in an informed and
  professional way?
- Was the adult or perpetrator subject to any other formal risk
  management arrangements, e.g. local Anti-Social Behaviour Strategy,
  MAPPA, MARAC, provisions under Mental Health or Mental Capacity
  Acts?
- Did actions accord with the assessment and decisions made?
- Were appropriate services offered in the light of the assessment?
- Were there any indicators that the adult refused services, advice or
  support offered?
- Was the adult at risk views taken into account when decisions were
  made?
- Where there any indicators that the adult may have lacked capacity to
  make decisions about his/her safety, wellbeing, or welfare.
- Was practice sensitive to issues of equality and diversity?
- Did other organisations respond appropriately to concerns raised?
- Was the work in this case consistent with the Multi Agency
  Safeguarding Adult Policy and Procedures?

What do we learn from this case?
Are there lessons about the way in which this organisation works to protect
adults at risk from abuse? Is there good practice to highlight as well as ways
in which practice can be improved? Are there implications for ways of working,
training, supervision, working in partnership or resources?

Recommendations
What action should be taken, by whom and by when? What outcomes should
be achieved and how will the organisation evaluate whether they have been
achieved? Does the case suggest that the BSAB may need to change its
local protocols or procedures or that protocols are not being adequately disseminated, understood or implemented?
Appendix 3

Bolton SAB Learning Lessons Panel - Terms of Reference

The standing SAR panel is a sub group of the SAB Executive Board. The standing chair and the membership of the Panel will be agreed by the Executive Safeguarding Adult Board.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult &amp; Community Services</td>
<td>Chair</td>
<td></td>
</tr>
<tr>
<td>GMP</td>
<td></td>
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<tr>
<td>GMW – Mental Health</td>
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<td></td>
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<tr>
<td>NHS Bolton</td>
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</tbody>
</table>

The Standing SAR Panel will

Review and improve the SAR Policy and guidance

Receive all formal notifications of cases which might require a Learning Lessons/Safeguarding Adults Review which will be submitted by Senior Managers of any agency using the Notification Form (Appendix 2)

Consider the merits of each notification and determine whether the safeguarding adult review criteria are met.

- Where the SAR criteria are met the panel will notify the chair of the BSAB and recommend an appropriate SAR chair/report writer and appropriate panel representation. *In many cases The Learning Lessons Panel will be appropriate, unless a panel member has had line management or other involvement in the case to be reviewed.*

- Where the SAR criteria are not met the panel will recommend another type of learning lessons exercise where appropriate.

Initiating a Safeguarding Adults Review

The Chair of Learning Lessons Panel will notify the proposed SAR Chair/Report writer and arrange a meeting with the SAR Panel

The Safeguarding Adult Review Chair and Panel will agree:

- Terms of reference
  - What appear to be the most important issues to address?
  - What is the period of time of events to be reviewed?
What background/social or family history is relevant and required for understanding of the case
Will the case give reason for parallel reviews? E.g. Domestic Homicide/ Mental Health/Coroner. How can these be co-ordinated to avoid duplication?
How should the review process take account of a Coroner’s enquiry and (if relevant) any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Crown Prosecution Service?

Who Should Contribute
Which agencies/workers
Need for external expert to contribute to analysis or enlightenment on a particular aspect of the case,
Need for involvement of another BSAB area, which agencies will this involve.
Family involvement. How should family be asked to contribute? By letter in person?
Is Legal Advice required?

Miscellaneous Considerations
What Evidence required from each agency – management review
The support and resources needed
Dates, times, venues of meetings
Determine who will author the report – this person may be the Chair or some other appropriate person who is independent of any involvement of the case or producing Internal Management Reports
How should any public, family media interest be handled before during and after the review

During the SAR
The SAR Panel will support and advise as necessary the Chair throughout. The Panel will meet with the Chair to discuss early findings when the chair/Report Writer has received all the Individual management Review Reports and again when The chair/Report Writer has prepared the final draft report.

Concluding the SAR/Monitoring Outcomes
The Chair will submit the report with recommendations to BSAB Exec

Once the BSAB has agreed the final report, recommendations and action plan the Standing SAR Panel will monitor outcomes and timescales and report back to BSAB

Frequency of meetings
The Standing Panel will meet twice a year to
review policy implementation
monitor lessons learned outcomes
• produce activity reports for BSAB

In addition the SAR Panel will meet as necessary to consider individual SARs.