Keeping Adults Safe in Shropshire
Safeguarding Adult Review Policy and Procedure

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Keeping Adults Safe in Shropshire Board

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With grateful thanks to the West Midlands Safeguarding Leads Group and Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

1. Introduction

The Care Act 2014 introduces statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews), mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

Criteria from s44 of the Care Act 2014:

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

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult* has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

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

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

* the adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

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2. Principles that guide Safeguarding Adult Reviews

The following principles apply to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- the individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- the Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and
- professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

3. The purpose of a Safeguarding Adult Review

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

The purpose of the reviews are not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, the General Medical Council and Coroner's Court.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

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4. Methodologies

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases, the SAB will need to weigh up what type of 'review' process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The ultimate decision to arrange a SAR is the responsibility of the Chair of the SAB.

The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for adults (who may have been seriously abused or neglected) and families and friends of adults who have died or been seriously abused or neglected.

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another.

4.1 Traditional Serious Case Review model

This model includes:

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning
- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

4.2 Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. There are a number of agencies and individuals who have developed specific versions of action learning models, including:

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

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The broad methodology is:

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

4.3 Peer review approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasingly used within Adult Social Care.

There are two main models for peer review:

- peers can be identified from constitute professionals/agencies from the Safeguarding Adults Board members or
- peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

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5. Duty of Candour

All members of a SAB are expected to have a culture of openness, transparency and candour within their day to day work and with the SAB. In interpreting this "duty of candour", we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice - as a member of the SAB all agencies have a responsibility to ensure it is open and transparent with the SAB when certain incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incident that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying own learning and multi-agency learning.

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6. Referral to the Keeping Adults Safe in Shropshire Board of a case that may meet the criteria for a SAR

Any agency or professional may refer a case believed to conform to the Safeguarding Adults Review criteria set out above. A referral must be made using the Referral Form (Appendix 1). This must include senior manager authorisation and will be submitted to the local authority Designated Adult Safeguarding Manager but should not be more widely circulated. They will acknowledge receipt of the notification and advise the Independent Chair of Keeping Adults Safe in Shropshire Board

All referrals will be submitted to the next Keeping Adults Safe in Shropshire Executive Board for initial consideration.

Once it is known that a case is to be considered at a Scoping Panel each agency should secure its records relating to the case to guard against loss or interference. It is each individual agency's responsibility to ensure there are internal processes in place that enable paper and electronic files to be secured whilst still enabling professionals to carry out their duties.

The local authority Designated Adult Safeguarding Manager will forward a 'Safeguarding Adults Review Scoping Panel Information Request Form (Appendix 2) to the Board and the Executive Board and other relevant agencies. It will include a date by which the form must be completed and who it must be sent to. This information does not need to include analysis at this stage, but there must be sufficient detail for the members of the Scoping Panel Meeting to make a recommendation about who should attend a scoping panel and in time, whether or not there should be a SAR.

Agencies also have a responsibility for promoting confidentiality and sensitivity in the co-ordination and overall management of the review process. All reports must indicate their confidential nature and be password protected in accordance with each agency's information governance procedures.

7. Conducting a Safeguarding Adults Review

The Chair of the Keeping Adults Safe in Shropshire Executive Board will, in conjunction with the local authority Designated Adult Safeguarding Manager, be responsible for ensuring administrative arrangements are completed and the review process is conducted according to the stages described below and the timescales outlined.

i. Establishing a Scoping Panel
ii. Evidence and information collection
iii. Receipt of evidence (Review Panel)
iv. Production of the action plan
v. Implementing the review recommendations

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i. Establishing a Scoping Panel

A Scoping Panel will be convened and will be chaired by the Keeping Adults Safe in Shropshire Executive Board Chair or Vice Chair. Where appropriate, members of the Executive Board will be core members of the Scoping Panel and additional members may be co-opted by the Chair for their skills and experience relating to the individual case. Attendance will be required from each agency holding information. This will be a manager who has no direct involvement with the case.

The role of the Scoping Panel is to:

- review the information known to the relevant agencies
- determine whether or not the criteria for a SAR is likely to have been met
- make a recommendation to the Independent Chair of the Keeping Adults Safe in Shropshire Board who is the decision maker in respect of whether a SAR will be undertaken.

The Scoping Panel meeting should, wherever possible, aim for a consensus not a majority view in its recommendation. The multi-agency nature of a Safeguarding Adult Review is such that it is important the way forward is agreed as a partnership. A Supporting Criteria Document is attached at Appendix 3 to assist Scoping Panel members in their considerations. If the decision of the Independent Chair of the Keeping Adults Safe in Shropshire Board is that the criteria for a SAR is not met, they will write to the referrer informing them of this decision and the rationale. If the decision is that the criteria for a SAR is met, they will write to the referrer informing them of this decision.

a) Terms of reference and scope of the review

The Scoping Panel will propose:

a) terms of reference and scope of the review

b) the proposed methodology

The questions that should be considered when agreeing the above are outlined in Appendix 4, Scope of the Review Document. The local authority Designated Adult Safeguarding Manager will forward the recommendations of the Scoping Panel to the Independent Chair (if not present at the Panel) of the Keeping Adults Safe in Shropshire Board for their approval and/or amendment.

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b) Methodology

There will be a need to consider the budgetary impact when undertaking a SAR or other review process and this will be the responsibility of the Scoping Panel when considering its decision regarding the proposed methodology. It is important that the intensive resources required for an effective SAR are only used to ensure the greatest learning and multi-agency practice development for the partnership. 'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' (March 2013) provides some clarity in relation to this issue:

"*Cost effectiveness is an issue for Safeguarding Adults Boards as an independent commission can prove expensive and in some areas there is an all-or-nothing approach to commissioning reviews. Some Boards, and very recently all the London authorities, have developed a proportionate approach which offers Boards a range of options to match against the seriousness and circumstances of the case, allowing a faster and more cost effective response while maximising the Board's learning*."

Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options. Additionally to those listed above, Shropshire considers the following methodologies appropriate to be considered a SAR:

- Significant event analysis
- Multi-agency review process
- Single agency review process
- Case file audit (multi or single agency)

The Keeping Adults Safe in Shropshire Executive Board will be responsible for arranging a Review Panel and appointing a Chair.

ii. Evidence and Information Collection

The presentation of evidence and information collected will be dependent on the methodology used. However, as a minimum standard each agency involved will be expected to complete a detailed chronology of events to include comments on the quality and appropriateness of interventions, highlighting any discrepancies and providing recommendations for action. Guidance for Compiling a Chronology and a Chronology Template and is attached at Appendix 5 and 6 respectively and will be circulated by the Keeping Adults Safe in Shropshire Board Administrator. All information must be returned within the timescales set to the Administrator before the Review Panel is held.

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iii. Receipt of Evidence (Review Panel)

A Review Panel will be convened and may be chaired by the Independent Chair of the Keeping Adults Safe in Shropshire Board or anyone else from one of the partnership agencies appointed by them. The Chair must not be connected to the case. The Chair will be responsible for ensuring that all agencies are properly represented at the Review Panel and that they contribute to the process, completing any tasks in the timescales agreed, and reporting any lack of engagement or other blockages to progress to the Keeping Adults Safe in Shropshire Board.

The Review Panel will be made up of representatives from the agencies involved in the SAR, but who have not had any direct management or involvement in the case. Additional members will be co- opted by the Chair, e.g. Board members not involved in the case for their independent scrutiny and challenge or individuals for their skills and experience relating to the specific case. The relevant Local Authority will be asked to provide a representative from their legal team to attend meetings and advise the Review Panel on legal aspects of the case.

This stage of the process is a formal session where the Review Panel will propose timescales for completion and consider how the adult with care and support needs, their family and/or their advocate will be engaged. Any likely media interest will also need to be considered. The principal objective of identifying any learning to prevent future deaths/serious incidents must be balanced against the views of the adult, their family and/or their advocate which are an important element of the considerations of the Review Panel.

Agencies will share their chronologies and all other relevant information and agency representatives may be invited to clarify and raise queries from their reports. Each agency involved will be asked to:

- Present their chronology and any other reports and relevant information
- Participate in the cross-referencing of all agency information and any additional reports commissioned from any other source
- Form a view on practice and procedural issues
- Agree the key points to be included in the final proposals for action

The Review Panel will meet as required to review progress and at significant points in the process. They will note any areas of learning and acknowledge any examples of good practice identified through the review.

The Chair will provide progress updates to the Keeping Adults Safe in Shropshire Board.

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The Review Panel will consider whether there are links to other constituted Boards, e.g. LSCBs or Community Safety Partnerships or identify cross-boundary issues and whether an appropriate representative should be invited to the group. Should information regarding significant individual and/or organisational omission be received, the Chair will be notified without delay. They will consider whether escalation to the Keeping Adults Safe in Shropshire Board will be required.

iv. Production of the Action Plan

The Review Panel brings together the information collected, analyses it and makes recommendations about what action should now be taken. This Action Plan (Appendix 7) will outline:

- Who will be responsible for actions
- The timescales for completion of agreed actions
- The intended outcome and purpose of recommended actions
- The model used for evaluating, monitoring and reviewing improvements in practice, policy and/or systems

The Review Panel will quality assure it prior to presentation to the Keeping Adults Safe in Shropshire Executive Board. In some methodologies the Action Plan may be incorporated into an Overview Report.

v. Implementation of the action plan

The Action Plan will be presented to the Keeping Adults Safe in Shropshire Executive Board which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented
- Produce an Executive Summary suitable for public circulation and that includes key learning points for agencies
- Agree mechanisms for the dissemination of the Executive Summary and feedback to the adult, their family and/or their advocate, staff or any other interested party
- Be responsible for monitoring the implementation of all recommendations on the Action Plan and reporting on progress to the Keeping Adults Safe in Shropshire Board.
- Make arrangements to provide feedback to staff and the media as appropriate

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- Implement those actions for which the Keeping Adults Safe in Shropshire Board has lead responsibility and monitor the timely implementation of the SAR action plan
- Formally conclude the review process when the Action Plan has been implemented and notify any formal body as appropriate
- Ensure that any SAR undertaken is referenced in the Keeping Adults Safe in Shropshire Board Annual Report

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Appendix 1.

Safeguarding Adult Review
Referral Form

The Executive Board of the Keeping Adults Safe in Shropshire Board (KASiSB) considers every referral on the basis of whether it meets the criteria for a Safeguarding Adult Review. As much information as possible is needed to enable members to make a proportionate decision as to how to respond to a referral, ensuring if the case is accepted for a review, that maximum learning is achieved. Please complete as much information on this form as possible and submit to the local authority Designated Adult Safeguarding Manager (sarah.hollinshead-bland@shropshire.gov.uk).

Referrer

Name:	
Role:	
Agency (where applicable):	
Address:	
Telephone number:	
E-mail:	

Senior Manager Authorisation

Name:	
Role:	
Telephone number:	
Address:	
Email address:	
Date referral authorised:	

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Adult with care and support needs

Name:	
Address:	
Date of birth:	
Summary of care and support needs (include both physical and mental health needs (where applicable):	
Date of Adult Safeguarding concern (where applicable):	
Summary of the Adult Safeguarding concern (where applicable):	
Date of death/serious injury (where applicable):	
Name and contact details of adult's representative and/or advocate:	
Details of GP:	
Agencies involved:	
Other relevant information:	

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About this referral

Please state why you think this person should be considered for a Safeguarding Adults Review with reference to the criteria as outlined on page 3?	
Please give detail of any form of learning/incident review in relation to this case including recommendations from those processes (e.g. Serious Incident Investigation, Root Cause Analysis, Complaint investigation etc.) This should also include the impact (both actual and anticipated) arising from these recommendations	
Please detail any other relevant information that will enable the KASiSB Executive Board to reach a decision about how to respond to this referral	

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Appendix 2

SAFEGUARDING ADULTS REVIEW
SCOPING PANEL INFORMATION REQUEST FORM

Name of adult:	**[text]**	Alias:	**[text]**
DOB:	**[text]**	CareFirst No.	**[text]**
Last known address:	**[text]**	NHS No.	**[text]**

The following information is required to identify which agencies need to attend the Scoping Panel on

Date: **[text]**
Time: **[text]**
Venue: **[text]**

OTHER HOUSEHOLD MEMBERS								
First Name	**Surname**	**Gender**	**Known as / Alias**	**DOB**	**Relationship to Adult**	**National Health Ref. Number**	**Ethnic Origin/ Background**	**Address**
OTHER SIGNIFICANT PEOPLE								
First Name	**Surname**	**Gender**	**Known as / Alias**	**DOB**	**Relationship to Adult**	**NHS/CareFirst Nos.**	**Ethnic Origin/ Background**	**Address**

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Name of agency providing information:
Name of team:
Name and designation of the individual completing this form:
Date completed:

	Question	Yes	No
Adult:			
1.	Is the above named adult known to your agency?		
2.	Is the above named adult currently receiving services from your agency or a service you commission? *(If a commissioned service please give contact details of the provider)*		
		Details:	
3.	Do historical records exist in your agency in relation to this adult? *(If yes please provide approximate dates).*		
		Details:	
Household Members:			
4.	Is any other member of the above named adult's household known to your agency? *(Please refer to the attached 'Review by Management Information Sheet' for details).*		
5.	Where a household member, other than the named adult is known to your agency please identify:		
a	The household member's name/DOB/relationship to the adult		

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b	Are they currently receiving services from your agency*? (If yes please provide brief details)*		
		Details:	
Other Significant People:			
6.	Is any other significant person known to your agency?		
7.	Where any other significant person is known to your agency please identify:		
a	Their name/DOB/relationship to the adult		

b	Are they currently receiving services from your agency*? (If yes please provide brief details)*	Details:
Other relevant information:		
	Please note any further information that you think may be helpful. *This could be for example; other family members or significant people involved in the life of the adult; other addresses; dates of birth; or agencies.*	Any other Information:
	Please identify who your agency representative will be throughout the SAR process should this be progressed and your agency be identified as relevant. Please provide their contact details.	

Please return this form in a secure manner by **[Date]** to sarah.hollinshead-bland@shropshire.gov.uk

The Designated Adult Safeguarding Manager will notify agencies to confirm whether or not they are required to attend the Scoping Panel Meeting once all of these forms have been returned.

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Appendix 3

Safeguarding Adults Review
Supporting Criteria Document

The purpose of this criteria is to support Scoping Panel Meeting members in their considerations. It is important that the intensive resources required for an effective Safeguarding Adult Review are only used to ensure the greatest learning and multi-agency practice development for the KASISB.

A Safeguarding Adults Review ***should*** be conducted when:

- an adult in the KASISB area who has care and support needs (whether or not the local authority was meeting any of those needs) dies, **and** abuse or neglect is known or suspected to be a factor in their death; **or**

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

A Safeguarding Adult Review should be ***considered*** when an adult in the KASiSB area has care and support needs (whether or not the local authority was meeting any of those needs) and when abuse or neglect is known or suspected to have taken place and the adult at risk has experienced:

  - serious sexual abuse

  - organisational or systemic abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a number of people's well-being and is of a nature where there are serious negative outcomes for the individuals concerned

In deciding whether a Safeguarding Adult Review should be conducted the following questions may be helpful:

- Do the operational case details give reason for concern about the way in which professionals and services worked together to safeguard the adult?

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- Is there clear evidence of a risk of significant harm to an adult that was not recognised or shared by professionals or agencies?
- Are there concerns about how agencies have worked together to prevent, identify minimise or address a risk of significant harm and may place other adults at risk of significant harm?
- Are there actions or omissions in a number of agencies involved in the provision of care, support or safeguarding of an adult that may have caused or be implicated in their harm?
- Does one or more professional, agency, family member, carer or advocate consider that their concerns were not taken seriously or acted upon appropriately?
- Does the case indicate that there may be operational failings in one or more aspects of the use of the KASISB Policies and Procedures?
- Was the adult subject to unauthorised Deprivation of Liberty?
- Was there evidence of discrimination?

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Appendix 4

Safeguarding Adult Review
Scope of the Review Document

The Scoping Panel will consider the terms of reference and scope of the review including the following elements:

- What appear to be the most important issues to consider in trying to learn from this specific situation?
- How can the relevant information best be obtained and analysed?
- Which methodology should be used to facilitate learning?
- Over what time period should events be reviewed?
- What information from family or service history will assist the SAR Panel?
- Which agencies and individual professionals should be asked to participate in the review and who else should be asked to submit reports or otherwise contribute?
- What is the most appropriate method to enable the adult, their family, carers or representatives/advocates participation?
- How should the review process take account of a Coroner's enquiry or any criminal investigation or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Crown Prosecution Service?
- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/agencies who will be required to participate in the review?
- Might it help the review panel to bring in an outside expert at any stage to shed light on crucial aspects of the case?
- Is there a need to involve agencies/professionals in other Safeguarding Adults Board areas and what should be the respective roles and responsibilities of the different Safeguarding Adults Boards with an interest?
- Is there a need to involve other partnerships for example the Local Safeguarding Children Board, MAPPA etc?
- Who will make the links with relevant organisations outside the main statutory agencies, e.g. independent professionals, independent providers, voluntary organisations?
- What is the nature and extent of legal advice required, particularly in relation to Data Protection, Freedom of Information and the Human Rights Act?

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- Is there a need for completion and implementation of media and communications plan?
- When should the review process start and by what date should it be completed?

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Appendix 5

Safeguarding Adult Review
Guidance on Compiling a Chronology

What is a Chronology?

The chronology provides a succinct summary and sequential overview of significant events in the adult's life. It contributes to an emerging picture where current information is understood in the context of previous information. A chronology should be used as an analytical tool to help understand the immediate and cumulative impact of events.

Not only are they a means of organising and merging information, they also enable practitioners to gain a more accurate picture of the whole case and highlight any gaps and missing details that may require further assessment. They:

- Provide a mechanism through which information can be systematically shared and merged
- Enable agencies to identify the history
- Provide invaluable information about an adult's experience
- Can reveal risks, concerns, patterns and themes, strengths and weaknesses
- Identify previous periods of professional involvement/support and the effectiveness of these interventions
- Inform assessment, decision making and analysis

General Principles

The chronology must be completed on the template provided. It may be helpful to supplement a chronology with a report that draws out key themes and messages. Information recorded in a chronology should be relevant. Whilst professional judgement is required to decide on the relevance of particular events, all should be included if there is any doubt.

The relevance and/or significance of an event can change over time. An historical event which appeared insignificant or irrelevant may become relevant and significant in the light of further information of more recent origin. Where there is no agency contact for periods during the timescale of the review this should be made clear in the chronology.

Where abbreviations are used a glossary must be provided. The chronology must be approved by a senior officer/manager prior to submission.

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Significant Events

A significant event is an incident that impacts on the adult's safety and welfare, circumstances or living environment. This will inevitably involve a professional decision and/or judgement based upon their individual circumstances.

The following are examples of key incidents pertaining to the adult, household members and significant other people that should be included on a chronology. This is not an exhaustive list and it is essential that practitioners use their professional judgement in identifying pertinent information:

- Views and wishes of the adult and/or their representative
- Contacts or referrals including self-referrals and any referrals to other agencies /teams
- Assessments undertaken
- Strategy discussions, meetings and conferences
- Events showing capacity and/or willingness to work in partnership and engage with professionals
- Specific support/guidance requested and/or offered
- Appointments kept or missed
- Any event deemed to have a significant impact on the adult such as separation from the main carer
- Significant injury or neglect events
- Self-harm, attempted suicide or overdose
- Absconding behaviour and/or missing episodes
- Environmental factors such as moving residence or changes in household composition, e.g. births, deaths, individuals moving into or out of the household, living conditions, employment
- Financial arrangements
- Family and social relationships
- Frequent presence of unknown individuals
- Access that was denied and by whom
- Health issues including attendance at or admission to hospital
- Change in GP
- Police logs detailing relevant incidents such as concerns for safety, mental health issues, domestic abuse, anti-social behaviour, drug and/or alcohol misuse
- Criminal or civil proceedings and outcomes
- Any changes in legal status

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There may be core incidents involving professionals that could be significant depending on the circumstances:

- Communications between professionals within an agency and/or between agencies
- Supervision of staff
- Training of staff
- Turnover of staff

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Keeping Adults Safe in Shropshire Board

Appendix 6

Safeguarding Adult Review
Chronology Template

Name(s) of Adult(s): [Text]

Name of Agency: [Text}

Name, job title & contact details of person authorising submission of chronology: [Text]

Dates to be covered by the chronology: [Text]

Date of submission: [Text]

Time & Date *The time and date of the event*	**Source** *Agency, individual, case records, letter, report, minutes, interview, etc*	**Event** *The significant event or piece of information*	**Name** *Individual involved in the event*	**Outcome** *Any action taken or decisions made in response to the event*	**Comment** *Appropriateness or quality of the intervention* *(please highlight good practice as well as areas for development)*	**Recorded By** *Individual adding information to the chronology*
00:00 dd/mm/yyyy						

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Appendix 7

Safeguarding Adult Review
Action Plan Template

Recommendation *(From the Safeguarding Adults Review - to be completed by KASISB Executive Board)*	**Relevant Agencies** *(Agencies required to implement this action – to be completed by KASISB Executive Board)*	**Action** *(Specific actions to be undertaken to implement the recommendation - to be completed by agency)*	**Deadline** *(When action is due to be completed - to be completed by agency)*	**Supporting Evidence and Update** *(Evidence that will be sent to KASISB to demonstrate action has been completed - to be completed by agency. To be RAG rated by KASISB Executive Board once complete)*

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Appendix 8

Safeguarding Adult Review
Interface with Other Reviews

Review	Precedence
Domestic Homicide Reviews (DHR) Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	When the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that: the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by - (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Children's Serious Case Review (SCR) Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. For further guidance see – HM Government - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children 2013	When abuse or neglect is known - or suspected - and either: • a child dies • a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child

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Suicide (Serious Incident Investigation/ Root Cause Analysis)	When a person who is in contact with mental health services (or has recently been involved in services) experiences a serious negative outcome including an unexpected death then a Serious Incident Investigation including a Root Cause Analysis would be required in order to identify and implement any learning associated with the management of that person's care.
Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review Criminal Justice and Court Services Act 2000 - strengthened by the provisions of the Criminal Justice Act 2003 (s325−327).	When the main purpose is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.
Serious Further Offending Notification and Review Procedures Offender Rehabilitation Act 2014	Reviews will be required in any of the following cases:- - any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the NPS or a CRC; or whilst subject to ROTL. In addition, this will also apply during the 28 day period following conclusion of the management of the case; or - any eligible offender who has been charged with another offence on the SFO qualifying list committed during a period of management by the NPS or a CRC and is or has been assessed as high/very high risk of serious harm during the current sentence (NPS only) or has not received a formal assessment of risk during the current period of management; or

	- any eligible offender who has been charged with an offence, whether on the SFO list or another offence, committed during a period of community management by the NPS or a CRC, and the provider of probation services or NOMS has identified there are public interest reasons for a review. This may be due to significant media coverage Ministerial interest or where reputational risks to the organisation may arise; or - if the offender has died and not been charged with an eligible offence but where the police state he/she was the main suspect in relation to the commission of a SFO.

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