

**Worcestershire Safeguarding Adults Board**

**Safeguarding Adult Review of NAME**

# TERMS OF REFERENCE

## Introduction:

1.1 Information circumstances about referral

1.2. Information about the adult

## Supporting Framework:

2.1. The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

2.2. Section 44, Safeguarding Adult Reviews**:**

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

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

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

1. 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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.3. This Safeguarding Adult Review is being held in accordance with the Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol criteria **1**. This states that "*the Worcestershire Safeguarding Adults Board must arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. Statutory Guidance on these criteria is provided in Chapter 14 of the Care and Support Statutory Guidance, at paragraphs 14.133 and 14.134. Therefore, the Board* ***must*** *undertake a Safeguarding Adults Review under the following circumstances;*

*when an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) dies and the Worcestershire Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it know about or suspected the abuse or neglect before the adult died)."*

## Methodology:

3.1. This Safeguarding Adults Review will primarily use an investigative, systems focused and Individual Management Review (IMR) approach. This will ensure a full analysis - by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key front line staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

## Scope of Safeguarding Adult Review:

4.1. Adult: **NAME :** Date of Birth: XXX

Date of Death: XXX

4.2. Timeframe

The scope of the SAR will be from DATE to DATE

4.3. In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case

## Agency Reports:

5.1**.** Agency Reports will be commissioned from:

* Name of agency
* Name of agency
* Name of agency
* Name of agency
* Name of agency

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3 Any references to the adult, their family or individual members of staff must be in a non-identifiable format as per the Caldicott Principals.

5.4 Any reasons for none cooperation must be reported and explained.

5.5 All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

5.6 It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7 It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the SAR.

5.8 SAR Panel members (or stated nominated member of that organisation) will monitor action plans as identified in section 8 of the IMR and provide WSAB assurance of their progression/completion prior to the completion of the SAR which will be fed into the final SAR report. Updates will then be requested until all actions are completed. Any issues in regards to lack of completion or lack of communication in regards to an action plan will be escalated by the SAR Chair to WSAB following the [Escalation Procedure.](http://www.worcestershire.gov.uk/downloads/file/6396/wsab_multi-agency_escalation_procedure_for_individual_cases)

5.9 It should be noted by all agencies that the adult/family will be updated on the outcome of the actions identified in the SAR by the Chair of the CR Sub Group

## Areas for consideration:

1. How the agency held Making Safeguarding Personal at the centre of the services provided to XX
2. How and when MCA and DoLS were applied and how this was documented
3. Are there ways of working effectively that could be passed on to other organisations or individuals?
4. Specific issues to be addressed in IMR
5. Specific issues to be addressed in IMR
6. Specific issues to be addressed in IMR
7. Specific issues to be addressed in IMR

## Engagement with the adult/family

7.1. While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the adult/family and details of their involvement with the Sar are included in this.

7.2. All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

7.3 Firstly this is in recognition of the impact of XXX experience/death. In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Worcestershire Safeguarding Adults Board.

7.4. Worcestershire Safeguarding Adults Board are responsible for informing the adult/family that an Independent Reviewer has been appointed.

## Media Reporting

8.1 WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB’s approval

8.2 During the SAR process any enquiries from the press in relation to the SAR are to be passed to the WSAB Coordinator

## Publishing

9.1 It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

9.2 Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

9.3 The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

9.4 Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

9.5 Whenever appropriate an 'Easy Read' version of the report will be published.

## Administration

10.1 It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account or the WCC Cisco system. Failure to do so will result in data breach.

10.2 The Board Co-ordinator will act as a conduit for all information moving between the Chair, IMR authors, Panel members and the Case Review sub group

## Confidentiality

11.1 All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Independent Author or the Case Review Chair.

## Timetable for Safeguarding Adult Review

| **Item** | **Date** |
| --- | --- |
| Scoping Meeting to agree on Panel members, terms of reference, methodology etc. Letter to IMR agencies to identify authors and secure documents | DATE |
| First introduction and discussion with the adult/family | DATE |
| Panel Meeting and Authors' briefing | DATE |
| Completion date for IMRs | DATE |
| 2nd Panel (scrutiny of IMRs) | DATE |
| First draft of Report circulated to Panel members for feedback | DATE |
| Second draft of the report send out to Practitioner Event attendees | DATE |
| Practitioner Event - Front line staff involved in the delivery of services attend an event to help create a better understanding for the SAR Author of the events that took place. | DATE |
| Update on Single Agency Action Plans feedback to SAR Author by IMR Authors for inclusion in final report | DATE |
| Final draft of report completed and 2nd meeting with adult/family to consider final draft and suggest amendments. Any amendments made to final draft following meeting with adult/family | DATE |
| 3rd Panel meeting to approve final draft of the report and draft SAR recommendations. Any amendments made to final draft following panel meeting | DATE |
| Safeguarding Adults Review Sub Group meets to consider final draft report and SAR recommendations | DATE |
| Final draft report and SAR recommendations circulated to Worcestershire Safeguarding Adults Board members. | DATE |
| Worcestershire Safeguarding Adults Board meets to consider final report. | DATE |
| WSAB Sub Group Chairs meet (with SAR Author if required) to determine multi-agency action plan from the SAR recommendations | DATE |