Version	Date	Author / Reviewed by	Comments

Instigating and Undertaking a Case Review Learning Process

Wigan Safeguarding Adult Board

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1 Introduction by Dr Suzanne Smith – Independent Chair Wigan Safeguarding Partnership

Wigan Safeguarding Adults Board is committed to improving the outcomes for adults at risk of neglect and abuse through its learning and improvement activity. The Board supports and will incorporate all learning and at all levels from across partner agencies. A separate Learning and Improvement Framework has been commissioned to identify where those opportunities can be harnessed into improving practice, policy and process and commissioning of services to improve outcomes for residents and users of services.

This document sets out the case review processes for Adults to ensure that all staff involved are clear in the steps they are asked to follow from referral through to case review reporting, their role within the process and how case reviews will be held and run. The process is designed to ensure that not only statutory requirements in terms of cases that hit the threshold of the Care Act are set out and clear, but the Wigan model allows for review of cases that might not hit critical threshold. This is to ensure that any learning can be extracted through a robust, inclusive and blame-free process and that cases that can be described variously as "near misses" or even "positive practices / outcomes" can be incorporated within the Boards learning process. The Board recognises that learning from these cases is often shifting the learning and system changes further upstream from a preventative perspective. In the case of celebrating positive outcomes borne out of individual practitioner skills or partnership working hold as much (if not more) value to multiagency staff than simply maintaining a focus on high threshold and after the event serious incidents.

It also acknowledges that even in the most serious of incidents and case reviews, that Wigan has a committed and positive staff across all agencies and that good practice exists even within the most complex or serious case. The Board has discussed and will actively promote positive learning throughout the case review process and that does not apportion blame to individuals or agencies – there are processes equipped to deal with this outside of the Board's core review responsibilities. The onus is on the learning that will change our system responses that in turn lead to better outcomes for everyone in need of safeguarding in the Borough.

Put simply, the purpose of conducting case reviews at all levels is not to reinvestigate or to apportion blame, it is:

- To establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard vulnerable adults.
- To review the effectiveness of procedures or commissioning of services.
- To inform and improve local inter-agency practice.
- To improve practice by acting on learning.
- To inform training provision.
- To highlight good practice.

With this in mind, the Board will push a positive message across all agencies asking partnership staff to refer in both serious cases, near miss type cases and positive outcome cases, the learning process is the same for all and I urge you to help us improve by learning.

2. Legal Context:

In the case of adults, the Wigan Safeguarding Adults Board responsibilities at a statutory level are dictated by the Care Act 2014 which states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

As part of the Boards continued commitment to the prevention of suicides, every incident where any partner agency considers that a person may have died as a result of their own actions will be reviewed using the Brief Learning Review Model. The purpose of this process is to understand whether there is any learning that can be identified in a multi-agency forum from this incident that may help the partnership to take actions to reduce the risks of further incidents.

2.1 Information Sharing:

Information sharing as part of case review processes is covered in the WSP Information Sharing Protocol.

3. Safeguarding Adult Reviews (SAR)

3.1 Criteria

1. As set out in the Care Act 2014 A Safeguarding Adult Board (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. Either of the following conditions are 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. Each member of the SAB must co-operate in and contribute to the carrying out of the review with a view to:

   a. Identifying the lessons to be learnt from the adult's case, and

   b. Applying those lessons to future cases.

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

The Care Act criteria In Wigan is therefore set out as an Safeguarding Adults Review should be **conducted** when:

- an adult in the WSAB area who has needs for care and support (whether or not the local authority was meeting any of those needs)
- dies, **and** the WSAB 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)

Or

- does not die but the WSAB knows or suspects that the adult has experienced serious abuse or neglect

and in both cases

- there is reasonable cause for concern about how the WSAB or a member of it or any other person involved in the adult's care worked together to effectively protect the adult;

and

- there are **clearly identified areas of learning and practice improvement or service development** that have the **potential to significantly improve** the way in which adults are safeguarded in the future.

Care Act guidance outlines that in the context of SARs something can be considered as 'serious abuse or neglect' where, for example:

- the individual would have been likely to have died but for an intervention
- the individual has suffered permanent harm
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects)
- the individual has suffered serious sexual abuse.

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

- an adult in the WSAB 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 sustained:

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

- a potentially life-threatening injury

- serious or permanent impairment of development

- financial abuse where the outcome may have a long- term detrimental effect on a person's well-being and is of a nature where there are serious negative outcomes for the individuals concerned.

In deciding whether a Safeguarding Adults Review should be conducted the following questions may be considered:

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

- 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 serious 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 WSAB Policies and Procedures?

- Does the case involve serious or systematic organizational abuse from which learning could be transferred to other organisations to prevent such abuse or neglect in the future?

- Was the adult subject to unauthorised Deprivation of Liberty?

- Was there evidence of discrimination?

- Is there adverse media interest or serious public concern?

- Do the issues link to the strategic priorities of the WSAB?

- Would a SAR enable the WSAB to tackle practice issues before harm arises?

3.2 Determining a SAR in Wigan

A case is considered for reaching the above criteria through a Brief Learning Review (see Section 5). The professionals present will discuss the eligibility of a case and if the majority consensus is that levels are appropriate for SAR, the Wigan Safeguarding Partnership Business Manager will present the views of the review panel to the Independent Chair who will either accept or not the recommendation. If required, the case will be discussed as to eligibility at the next scheduled Adults Executive Group.

If the Brief Learning Review Panel do not judge the case to have reached a SAR threshold, learning would continue within the context of that group meeting and be reported back to the partnership via the tracker tool which evidences all decisions made regarding cases (see section 5).

3.3 SAR Methodology

Safeguarding Adult Reviews / Local Case Reviews can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies through independent reviewers and an independent panel involving two key stages. Individual agencies are asked to review the practice within their organisations through Individual Management Reviews and Chronologies which then form part of an Overview Report produced by an Independent Overview Report Author. It is permissible for the Panel Chair and the Overview Report Author to be the same person although the Board may wish to appoint a chair with specialist skills relevant to the thematic area of the case.

The WSAB will also consider may wish to use a blended learning approach. It may wish to draw on SARs from other areas that have been recently completed or conducting the learning as per a Brief Learning Review may be appropriate. In each case, the Adults Independent Chair will be asked their view and ultimately will mandate or not an approach that efficiently and effectively secures the learning. More recently, 'systems learning' (e.g., A model introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011), has been introduced as an alternative method. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in-depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. Other options may also be considered such as a hybrid of the traditional and more recent methods.

The Wigan Safeguarding Adults Executive can endorse the approach best suited to the circumstances of each individual case and the Learning and Improvement Subgroup will decide on the most appropriate method.

3.4 Grades of Staff within the Review Process

In the case of convening a review panel, it is advised that only representation from a manager at least two lines of responsibility from front line practitioners participates at panel meetings. This is to ensure that the panel remains focused on the strategic nature of the review regarding identifying and implementing improvements to organisations and multi- agency systems. It's recognised that this may not always be possible, in these circumstances' prior agreement between the agency and

the Wigan Safeguarding Partnership Business Manager regarding suitable attendance will be required.

Front line practitioners input is critical within the process, and through the production of chronologies of events, interviews with senior staff in the production of IMRs and appropriate attendance at systems thinking / learning events this input will be incorporated.

3.5 Governance

Safeguarding Adult Reviews are overseen by the WSAB Executive Group on behalf of the Board and reported back to the Board which is a multi-agency partnership with senior manager representation from all the key agencies in Wigan who work with adults at risk. They are responsible for ensuring that effective systems are in place for the effective completion of Safeguarding Adult / Local Case / Single Agency Reviews, for decision making in respect of commissioning reviews, formally accepting reports and agreeing sign off of the report for publication.

SARS will be presented in the first instance to the Safeguarding Learning and Quality Assurance Group and a decision made to either recommend its findings and action plan to the Executive, or request that further points are clarified or revisited by the review panel.

Involved organisations should be provided with copies of reports for comments on factual accuracy prior to final draft. Where a Safeguarding Adult Review Panel is established, it will be the role of the Panel to ensure the report is factually accurate and based on the evidence gathered during the process.

All involved agencies will be asked to contribute to a Lessons Learned Action Plan within the panel process, and this will form part of the overall Review report to be presented to and agreed by the WSP.

3.6 Timescales

Reviews must be completed in a timely manner. Once the decision to commission a SAR has been made, it should be completed and presented to the Wigan Safeguarding Adults Executive within 6 months, unless otherwise agreed by the Independent Chair / Director of Adult Services if an Independent Chair / Panel approach is deemed the most appropriate. Other methods may take a shorter period of time to complete.

Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Chair of the Board. It is acknowledged that where a Safeguarding Adult Review relates to serious institutional abuse or where multiple abusers re involved then such reviews are likely to be more complex and may require more time.

3.7 Media/communication and publication

Depending on the subject and findings of a review media and communication issues will be co-ordinated by the Wigan County Council Communications Team in collaboration with the communications teams of the other agencies involved.

Publication of the report and action plan will be decided by the WSAB on a case-by-case basis, acknowledging that in certain circumstances, family may wish to make representation to the partnership regarding not publishing a report, or asking that consideration be given to further anonymised versions of report and/or action plan. In these circumstances, the Independent Chair will decide based on discussion and advice given by Board members and inform family of the decision appropriately.

SAR report learning and recommendations will be published on the WSAB website via an executive summary format, whilst redacted copies of the report will be submitted through the SCIE portal to assist with national learning, themes and trends.

The Independent Chair through discussion and advice with the WSAB will consider the appropriateness (at point of publication) of releasing a statement outlining the reasons for the review, key findings and required actions.

3.8 Responsibilities to families

It is vital that families are made aware that the SAR is taking place and offered the opportunity of contributing to the review process.

The WSAB Manager through each individual case review panel process will identify an appropriate process to engage the family. Usually this will involve an organisation who has a positive relationship with the family. The family will be asked how they wish to be involved, including the offer of an independent advocate to attend and contribute to review meetings.

In certain circumstances where no positive relationship or offer can be made to family / carers, the Independent Chair of the Wigan Safeguarding Adults Board will contact the family and carers of the adult at risk as they think is reasonable to invite them to participate in the review process, but their consent is not required for the review to go ahead. (See Appendix Three for model letter template).

Family / Carers should be kept updated at key stages of the review and notified of the publication of the report. The WSAB Manager with assistance from review panel members will fulfil this role.

3.9 Responsibilities to staff

The staff directly involved in the care and support of individuals subject to a Safeguarding Adult / Local Case Review should be notified by the agency they are employed by of the decision to undertake a review and support should be provided to them.

The process and their involvement should be fully explained and for those unfamiliar with the process, they should be signposted to guidance as required. At the end of the process staff should be invited to a feedback session, co-ordinated by the WSAB Manager.

Particularly with the systems methodology it is vital that all agencies ensure there is internal support for those involved. This methodology is highly reflective, very interactive and while the benefits of collaborative analysis is positive, staff can feel challenged by this approach.

4. Learning and Improvement in the Safeguarding Adult Review Cycle:

In Safeguarding Adult Reviews and within the local context and interpretation of the guidance, the onus is on quick and effective learning embedded robustly and it is the responsibility of the Wigan Safeguarding Adult Board to ensure this is happening throughout the process rather than waiting for the conclusion of the review before doing so.

4.1 Parallel Learning processes:

In many cases the Safeguarding Adult Review may be running simultaneously with other defined learning process including:

- National Health Service Improvement processes such as the Strategic Executive Information System process (StEIS) and in cases where a case meets the definition of a patient safety incident it will also be subject to National Learning and Reporting System (NLRS).
- Independent Office of Police Conduct
- Greater Manchester Fire and Rescue Service serious incident review
- National Probation Service Serious Incident Review process.
- Mental Health Homicide Review
- MAPPA Serious Case Review
- LeDeR Review
- Domestic Homicide Review

The concurrent running of these processes will be discussed in Safeguarding Adult Review Panel meetings with the expectation of agencies connected to the processes sharing and emerging learning into the SAR Process. The Wigan Safeguarding Adult Board, Learning and Improvement Team will build this into the ongoing Action Plan for that Safeguarding Adult Review.

Where possible and/or appropriate, the Board may consider combining review processes. This will be the initial decision of the Adults Executive Groups and may require permission from national oversight panels.

During the SAR cycle, where any agency develops an action plan, undertakes any quality assurance work, audit, review activity or change to procedures in relation to an incident that triggered a Safeguarding Adult Review then the outcome of this will be shared with the Independent Reviewer.

4.2 Police Investigations:

Some Safeguarding Adult Reviews may be undertaken whilst there is an ongoing criminal investigation. The main point of contact between the Independent Reviewer will be maintained between the Wigan Safeguarding Adult Board Team and Greater Manchester Police's Serious Case Review Team. Regarding SARs, the Adults Executive Group will be kept informed.

4.3 Coronial Processes:

The Brief Learning Review, Safeguarding Adult Review cycles may run in parallel to a Coroner's investigation into a death.

The Wigan Safeguarding Adults Board Team will inform HM Senior Coroner for Greater Manchester West of all cases where a Safeguarding Adult Review is to be conducted on a case that is awaiting inquest.

Whenever a Coroner issues a Prevention of Future Deaths Report (Regulation 28 Coroners Act 2009) to one of the Safeguarding Partners, that partner organisation will inform the Wigan Safeguarding Adult Board Team both of the report, but also of their response to the Coroner. This will then be discussed and appropriately actioned at a future Wigan Safeguarding Adult Board Meeting.

4.4 Professional Registration body notifications :

Where a Brief Learning Review or SAR identifies issues around a member of the workforce that may meet criteria for notification to a registrant body e.g., Royal College of Nursing, Health and Care Professions Council, Social Work England, IOPC, General Medical Council then the Wigan Safeguarding Adult Board representative for their employing organisation will have responsibility for ensuring that appropriate notifications are made.

5. Brief Learning Reviews (BLR) :

A Brief Learning Review is a discretionary learning process. WSAB define discretionary as learning that hasn't met threshold for a SAR as defined by the Care Act. In certain circumstances the WSAB Business Manager will make a decision and inform the WSAB that a brief learning review should not take place. This includes circumstances such as (but not exclusively):

- Undertaking the review does not meet with the families wishes.
- Undertaking the review could adversely affect the wellbeing or the mental health of a family member.
- The brief learning contains elements of conjecture or inference that cannot be substantiated without official processes such as a police investigation / other formal professional review taking place and verifying those facts.

Where these or other circumstances are apparent within the referral, any decision to not undertake the review will be clearly documented and fed back to the WSAB and Independent Chair via the WSAB Business Units tracking framework.

Depending on the nature of the referral it may be a case that could be described as a "near miss", contains an element of learning that the practitioner considers crucial to system wide multi agency learning or may be a positive case where practitioners either singly or in partnership have achieved outstanding outcomes for the individual being supported.

In adult cases the BLR is also the process through which a recommendation will be made of whether the case may meet criteria for a Safeguarding Adult Review defined by the Care Act 2014.

The aims of a Brief Learning Review are:

(i) Ensure there is a coordinated and multi-agency response for the rapid identification of responses needed to safeguard others following serious safeguarding concerns.
(ii) Identify early learning and develop actions for improvement for Wigan Safeguarding Partnership.

A Brief Learning Review will be undertaken on the following cases (for example) :

- Any case where it is thought that a person has potentially died as a result of their own actions.

- When an agency identifies that there may be wider system learning from an active, or closed case.
- When an agency feels that there is benefit in sharing the effective multi-agency practice around a case so that the factors that have influenced this success can be identified and shared back into workforce development.

5.1 Referral Process For Brief Learning Review / Safeguarding Adult Review

In order to generate a brief learning review, the practitioner simply needs to fill in the generic Case Review Referral form (Appendix One) and send to p.whitemoss@wigan.gov.uk

When the WSAB Business Unit Team have received the notification:

- An email will be sent to all Safeguarding SPOC's using the secure email system enquiring whether they have known the subject / subjects in the last 12 months.

- This will be followed, if relevant, by a 2nd email inviting the Safeguarding SPOC or relevant agency representative to the BLR meeting, provide contextual detail of why the BLR is being requested and will include a request for information Proforma. This only requires information from the last 12 months of involvement.

There will be a minimum of 15 working days between the request for information and the BLR meeting, with all information requests being returned by end of Day 13.

5.2 Brief Learning Review Meetings and outcomes:

Brief Learning Review meetings will be chaired by a manager from the WSAB Team and will be scheduled to last 2 hours.

The meeting includes:

- Sharing of information to construct shared understanding of different agencies involvements / interactions with the subject.
- Opportunity for agencies to question / contextualise any points raised.
- Identification of key themes, main issues and any apparent learning points.
- Consideration of actions.

However, as a Brief Learning Review is a dynamic learning process the meeting will also explore issues iteratively using various reflective practice 'reflection-on-action' models (Kolb 4 stage model, Gibbs, Schon).

THERE WILL ALSO BE CONSIDERATION OF WHETHER THE AGENCIES PRESENT FEEL THE CASE MAY MEET THE CRITERIA FOR SAFEGUARDING ADULT REVIEW. THIS IS ADVISORY ONLY, THE WSAB BUSINESS MANAGER WILL INFORM THE INDEPENDENT CHAIR THROUGH THE TRACKING FRAMEOWRK OF ALL PANEL VIEWS, AND THEY WILL ULTIMATELY DETERMINE THE THRESHOLD OUTCOME THROUGH DISCUSSION WITH RELEVANT WSAB MEMBERS

5.3 Follow up meetings / Action tracking :

The aim of a Brief Learning Review is, wherever possible, to complete the learning process in the single meeting and set actions. Actions agreed will be tracked 'virtually' by the WSAB Learning and Improvement Team in line with the timescales set.

A BLR may require a follow up meeting, for example of practitioners that were involved in a case, or after parallel processes like Coroners or Health organisation investigations (e.g., STEIS) have concluded.

5.4 Implementing learning from Brief Learning Reviews:

Recommendations and actions generated from Brief Learning Reviews will be appropriately commissioned to the relevant agency shared in anonymised form with the most relevant appropriate Strategic Partnership Group relevant to the thematic learning from that BLR. Should there not be a Strategic Partnership Group aligned to the learning from that BLR then the WSAB Team on behalf of the Wigan Safeguarding Adults Board will convene a meeting of strategic leads for that purpose.

Wigan Safeguarding Adults Board

Brief Learning Review / Case Consideration Request Form

This Case Review Referral is:

- For practitioners working in Adult services.
- Ensure there is a coordinated and multi-agency response for the rapid identification of responses needed to safeguard others following serious safeguarding concerns.
- Identify early learning for improvement for partners of Wigan Safeguarding Adult Board.
- Consider whether the threshold for a wider local case review / safeguarding adult review is met and make recommendations to the Independent Chair and Board.

Please return completed forms to p.whitemoss@wigan.gov.uk

1. Referring Agency Details			
Agency		**Name**	
Tel No.		**Email**	
Date of referral		**Date of Incident**	

Please provide the following information:

Persons Details:	
Name	
Alias	
Date of Birth	
Address	
Ethnic Origin	
Date of Death	
Date(s) known to Service	
Significant others: (copy and paste box as necessary)	
Name	
Date of Birth	
Relationship	
Address	
Ethnic Origin	
Significant others:	
Name	
Date of Birth	
Relationship	
Address	
Ethnic Origin	

Please provide details of concerns:
Please provide brief details of YOUR agency's involvement including names, roles and contact details of key people involved. (Please indicate who you would consider important to attend the Brief Learning Review)
Please provide brief details of OTHER agency's involvement including names, roles and contact details of key people involved. (Please indicate who you would consider important to attend the Brief Learning Review)
Please provide identified areas of concern on which the Brief Learning Review should focus.
Please identify any immediate agency actions.

Appendix Two – WSAB Referral Process and Learning Levels for Brief Learning Review / Safeguarding Adult Reviews

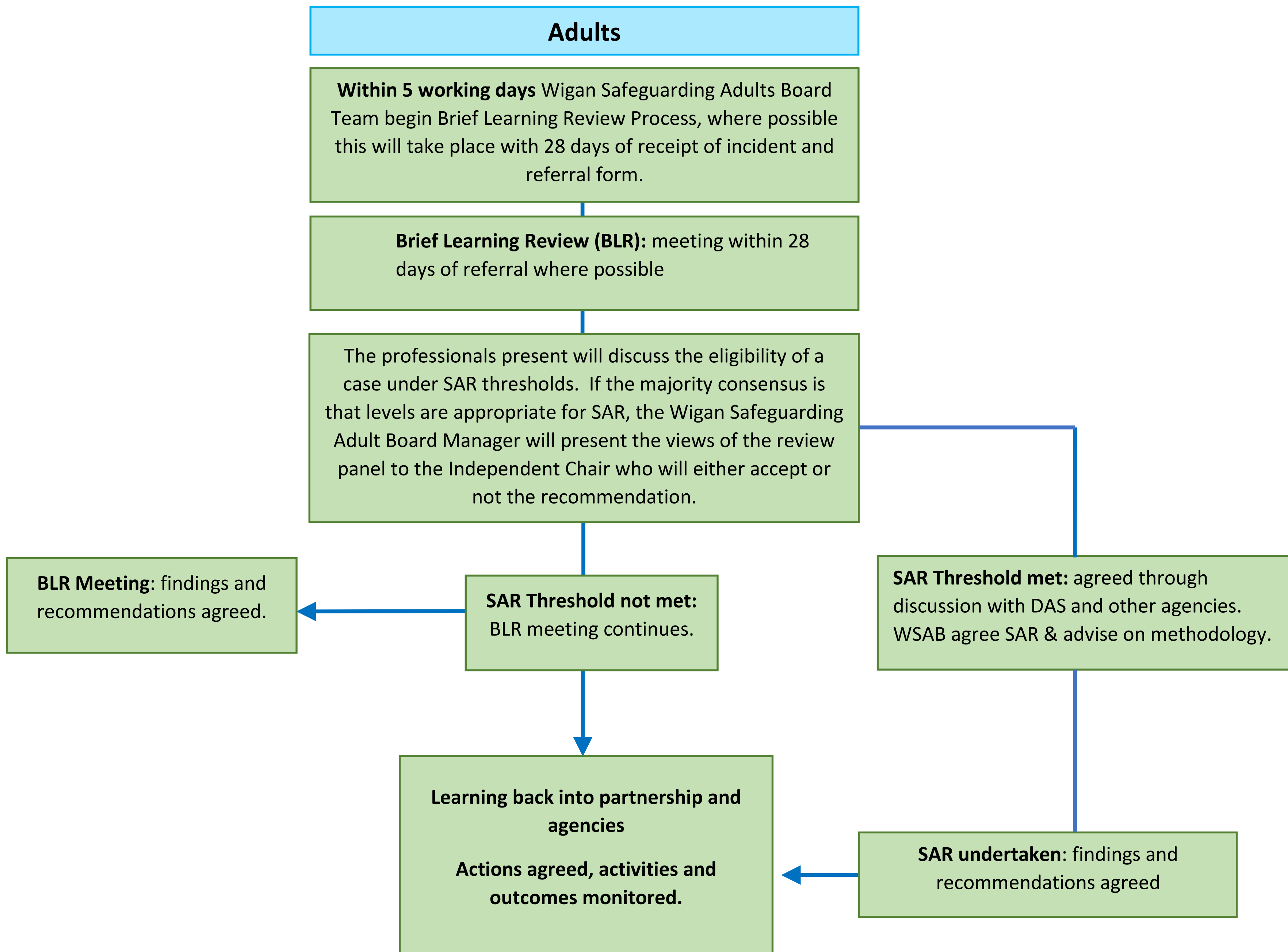
Wigan Safeguarding Adults Board

Adult incident or near miss, or has learning that other practitioners could benefit from

Adults good practice with outcomes that other practitioners could benefit from

Agency believes an incident has reached Safeguarding Adult Review threshold

Complete Case Review Referral Form and send securely to wsab@wigan.gov.uk


Adults
Within 5 working days Wigan Safeguarding Adults Board Team begin Brief Learning Review Process, where possible this will take place with 28 days of receipt of incident and referral form.
Brief Learning Review (BLR): meeting within 28 days of referral where possible
The professionals present will discuss the eligibility of a case under SAR thresholds. If the majority consensus is that levels are appropriate for SAR, the Wigan Safeguarding Adult Board Manager will present the views of the review panel to the Independent Chair who will either accept or not the recommendation.
BLR Meeting: findings and recommendations agreed.
SAR Threshold not met: BLR meeting continues.
SAR Threshold met: agreed through discussion with DAS and other agencies. WSAB agree SAR & advise on methodology.
Learning back into partnership and agencies
Actions agreed, activities and outcomes monitored.
SAR undertaken: findings and recommendations agreed

Appendix 3

Your reference:

Please ask for:

Extension:

Direct line:

Date:

Dear

Safeguarding Adult Review

Wigan Safeguarding Adults Board has made the decision that a Safeguarding Adult Review should be undertaken to look into the death of <   >.

Safeguarding Adult Reviews are undertaken as governed by the Care Act of 2014. The main purpose of the review is to establish whether there is any learning about the way local professionals and organisations worked individually and together to safeguard the person(s) involved.

As part of the process contact is made with all the agencies, family members and other people who had contact with < > to see what they might know that might help to explain what happened. When this information is available, a panel made up of the agencies involved, meet to consider whether anything could have been done differently to prevent < > death. An anonymised report is then written.

As you are a family member, I am contacting you to find out whether you would like to contribute to the review; if you decide you do, please call or e-mail me using the contact details below. Anything you say to me will be completely confidential and will only be used with your consent.

Yours sincerely