WSAB Case Review Policy and Process

Wigan Safeguarding Adult Board

Version Control

Version	Date	Author / Reviewed by	Comments
1.0	Feb 2021	Paul Whitemoss	First Draft for comment by WSAB (Date)
2.0	April 2021	Paul Whitemoss	Second version following Board discussion and comments
3.0	November 2022	Paul Whitemoss	Independent Chair Updated - Additional criteria included under section 3.1 to aid decision making regarding SAR Threshold
4.0	November 2023	Paul Whitemoss	Review to incorporate refreshed decision-making processes and to incorporate wider learning opportunities
5.0	November 2024	Mike Wharton	Review to incorporate learning from last 12 months

Contents:

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 multi-agency learning opportunities from across the partnership.

A separate Quality Assurance Framework is in place to identify where those opportunities can be harnessed into improving practice, policy and process and commissioning of services to improve outcomes for residents and service users providing a means by which the WSAB can be assured of the quality of safeguarding services across the partnership..

This case review document sets out the learning processes at various levels for adults to ensure that all staff involved are clear in the steps they are asked to follow. The document covers staff and professionals' roles within the learning framework and how they will be part of how the learning activity is coordinated. The process is designed to ensure that not only statutory requirements in terms of cases that hit the threshold of the Care Act 2014 are set out and clear, but the Wigan model allows for review of cases that might not hit critical threshold, yet multi-agency learning is still present.

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 cases often shifts the learning and the system changes further upstream from a preventative perspective. Celebrating positive outcomes resulting in individual practitioner skills or effective partnership working holds significant value to multiagency staff, potentially even more focusing solely on high threshold, post-incident serious cases.

The Board recognises that even in serious incidents and case reviews, Wigan has dedicated staff across all agencies, and good practices exist even in complex cases. The Board will actively promote positive learning throughout the review process, focusing on system-wide improvements rather than individual or agency-specific issues. This approach aims to enhance our responses and achieve better outcomes for everyone in need of safeguarding in the Borough.

Put simply, the purpose of conducting learning around cases at all levels is to:
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 use the processes in this document to identify both serious cases, near miss type cases and positive outcome cases; whilst the learning process may slightly differ, the outcome is the same for all in terms of improved practice, policy and partnership working. We can only do this by a partnership approach to learning in which all partners are participants.

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.

Information Sharing:

Information sharing as part of case review processes is covered in the Wigan Safeguarding Partnership (WSP) Information Sharing Protocol.

3. Safeguarding Adult Reviews (SAR)

Criteria

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:

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

Either of the following conditions are met:

Condition 1 is met if:
The adult has died, **and**
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)

Condition 2 is met if:
The adult is still alive, **and**
The SAB knows or suspects that the adult has experienced serious abuse or neglect

Each member of the SAB must co-operate in and contribute to the carrying out of the review with a view to:

- Identifying the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases.

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.

When deciding whether to conduct a Safeguarding Adults Review, consider the following questions:

- Do the case details raise serious concerns about how professionals and services collaborated to safeguard the adult?
- Is there clear evidence of a significant risk of 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 the risk of significant harm, potentially placing other adults at risk?
- Are there actions or omissions by multiple agencies involved in the care, support, or safeguarding of an adult that may have caused or contributed to their harm?
- Does one or more professional, agency, family member, carer, or advocate feel that their concerns were not taken seriously or acted upon appropriately?
- Does the case suggest operational failings in the use of WSAB Policies and Procedures?
- Does the case involve serious or systematic organisational abuse from which learning could be applied to other organisations to prevent future abuse or neglect?
- Was the adult subject to unauthorised Deprivation of Liberty?
- Is there evidence of discrimination?
- Is there adverse media interest or serious public concern?
- Do the issues align with the strategic priorities of the WSAB? Would a SAR help the WSAB address practice issues before harm occurs?

Determining a SAR in Wigan

A case is considered for reaching the above criteria through the information submitted as part of a request for a SAR. The Learning, Quality and Assurance subgroup will review the referral and make a decision to progress as a SAR or BLR, the subgroup chair will seek approval of the decision with the independent chair.

The professionals present will discuss the eligibility of a case and if the majority consensus is that levels are appropriate for SAR, it will be progressed.

If the threshold for a SAR is not met, however 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 then the Learning and Quality Assurance Group will make a recommendation to the independent chair of its intentions to complete a Brief Learning Review. Please refer to appendix 1: The Wigan Process.

It is accepted that parallel processes in themselves present opportunities for multi-agency learning. E.g. Single agency reviews that are routinely undertaken (ie. Patient Safety Incident Investigations), and it is expected that this learning be shared with board for wider dissemination where felt appropriate as opposed to requesting similar review activity is coordinated through the WSAB.

SAR Methodology

Safeguarding Adult Reviews (SARs) and Brief Learning Reviews (BLRs) can be conducted through various methods. Traditional approaches involve independent reviewers and an independent panel, typically in two key stages. Individual agencies conduct reviews within their organisations through Individual Management Reviews and Chronologies, which are then compiled into an overview report by an Independent Overview Report Author. The Panel Chair and the Overview Report Author can be the same person, although the Board may prefer to appoint a chair with specialised skills relevant to the case's thematic area.

The WSAB might consider a blended learning approach, incorporating SARs from other areas or using a Brief Learning Review as mentioned earlier. In each scenario, the Adults Independent Chair will provide their opinion and ultimately decide on an approach that ensures effective and efficient learning. Recently, systems learning' models, such as those introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011, have 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 with and influence individual workers' 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.

Grades of Staff within the Review Process

When convening a review panel, it is recommended that only managers with at least two levels of responsibility above front-line practitioners attend the panel meetings. This ensures the panel remains focused on the strategic aspects of the review, particularly in identifying and implementing improvements to organisations and multi-agency systems. It is acknowledged that this may not always be possible. In such cases, prior agreement on suitable attendance must be reached between the agency and a member of the Wigan Safeguarding Partnership Business Unit.

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 individual management reviews (IMRs) and appropriate attendance at systems thinking / learning events this input will be incorporated.

Governance

The WSAB Executive Group oversees Safeguarding Adult Reviews (SARs) on behalf of the Board, a multi-agency partnership with senior managers from key Wigan agencies working with at-risk adults. They ensure effective systems for completing reviews, making decisions on commissioning, accepting reports, and approving them for publication.

SARs are first presented to the Safeguarding Learning and Quality Assurance Group, which decides whether to recommend the findings and action plan to the Executive or request further clarification from the review panel.

Involved organisations should receive draft reports for factual accuracy comments before the final version. If a Safeguarding Adult Review Panel is established, it ensures the report's accuracy based on gathered evidence.

All agencies contribute to a Lessons Learned Action Plan, included in the final Review report presented to and agreed with by the Board.

Timescales

Reviews must be completed promptly. Once a SAR is commissioned, it should be finished and presented to the Wigan Safeguarding Adults Executive within six months, unless the Independent Chair or Director of Adult Services agrees otherwise. Some methods may take less time.

Urgent issues identified during the review should be reported to the Chair of the Board immediately. Reviews involving serious institutional abuse or multiple abusers may be more complex and require additional time.

Media/communication and publication

Depending on the review's subject and findings, media and communication issues will be managed by the Wigan Council Communications Team, in collaboration with the

communications teams of other involved agencies.

The WSAB will decide on the publication of the report and action plan on a case-by-case basis. In some cases, families may request not to publish the report or to consider further anonymised versions. The Independent Chair will make the final decision after consulting with Board members and will inform the family accordingly.

Learning and recommendations from the SAR report will be published on the WSAB website in an executive summary format. Redacted copies of the report will be submitted to the SCIE portal to support 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.

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 2 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 the review panel members will fulfil this role.

Responsibilities to staff

Staff directly involved in the care and support of individuals under a Safeguarding Adult or Brief Learning Review should be informed by their employment agency about the review decision and provided with support. The process and their role should be clearly explained, and those unfamiliar with it should be directed at relevant guidance. At the end of the process, staff should be invited to a feedback session coordinated by a member of the safeguarding business unit.

With the systems methodology, it is crucial that all agencies provide internal support for those involved. This approach is highly reflective and interactive, and while collaborative analysis is beneficial, it can be challenging for staff.

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.

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 Patient Safety Incident Response Framework (PSIRF) 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 (SAR) Panel meetings, with agencies expected to share emerging learning. The Wigan Safeguarding Adult Board's Learning and Improvement Team will incorporate this into the ongoing Action Plan for the SAR.

Where appropriate, the Board may consider combining review processes. This decision will initially be made by the Adults Executive Groups and may require national oversight panel approval.

During the SAR cycle, any agency that develops an action plan, conducts quality assurance work, audits, reviews, or changes procedures related to the incident that triggered the SAR must share the outcomes with the Independent Reviewer.

Sometimes, it may not be clear if the legal criteria for a SAR are met until a parallel process reveals more information. In such cases, the organization may be asked to complete single agency learning processes and then submit the SAR request once further evidence and learning are obtained.

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.

Coronial Processes:

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 reports, but also of their response to the coroner. This will then be discussed and appropriately actioned at a future Wigan Safeguarding Adult Board Meeting.

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.

Brief Learning Reviews (BLR):

A Brief Learning Review is a discretionary learning process. WSAB defines discretionary as learning that hasn't met threshold for a SAR as defined by the Care Act. All BLR's will be reviewed at LQ&A and the group 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.

The incident has occurred during a time when similar learning themes have been addressed through pre-existing SAR's or BLRs and therefore the likelihood of new learning is minimal

A single agency process has occurred already identifying learning that can be shared.

If these or other circumstances are identified in the referral, any decision not to proceed with the review will be thoroughly documented and reported to the WSAB and the Independent Chair at the next Board Meeting.

Depending on the nature of the referral, it might be classified as a "near miss," include critical learning points for system-wide multi-agency improvement, or highlight a positive case where practitioners, either individually or collaboratively, have achieved exceptional outcomes for the individual being supported.

In adult cases the BLR is also the process through which a recommendation can be made to escalate the need for a Safeguarding Adult Review defined by the Care Act 2014 if further information comes to light demonstrating the need for a SAR.

The objectives of a Brief Learning Review are to:

- Ensure a coordinated, multi-agency response quickly identifying necessary actions to safeguard others following serious safeguarding concerns.
- Identify early learning opportunities and develop improvement actions for the 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 but not through multi- agency neglect.
- 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, the factors that have influenced this success can be identified and shared back into workforce development.

Unlike SARs, a BLR will not occur in parallel with processes identified above. It is expected that when the threshold for a SAR is not met, any single agency processes must be concluded and learning shared. A BLR may then be requested if multi-agency learning is potentially identified through the single agency process.

<u>Referral Process Safeguarding Adult Review</u>

All referrals will come via the SAR process initially and be stepped down to a Brief Learning Review where required. To potentially generate a Safeguarding Adult Review, the relevant agency needs to fill in the generic SAR Case Consideration Referral / Report Form (Appendix 3) and send to WSAB@wigan.gov.uk.

When the WSAB Business Unit Team have received the notification, it will be discussed at the next Learning and Quality Multi-Agency meeting to determine if the request has met the threshold for a SAR. If the threshold for a SAR is not met, then the referral will be considered against the above criteria to determine the benefit of completing a formal BLR.

If it is agreed to progress with the referral, an email will be sent to all Safeguarding SPOCs via the secure email system, inquiring whether they have had any involvement with the subject(s) in the last 12 months.

If relevant, a second email will follow, inviting the Safeguarding SPOC or the appropriate agency representative to the meeting. This email will provide contextual details explaining why the SAR / BLR is being requested and will include a request for information proforma, which only requires details from the last 12 months of involvement.

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

Meetings and outcomes:

Meetings will be chaired by a member 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.

A 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).

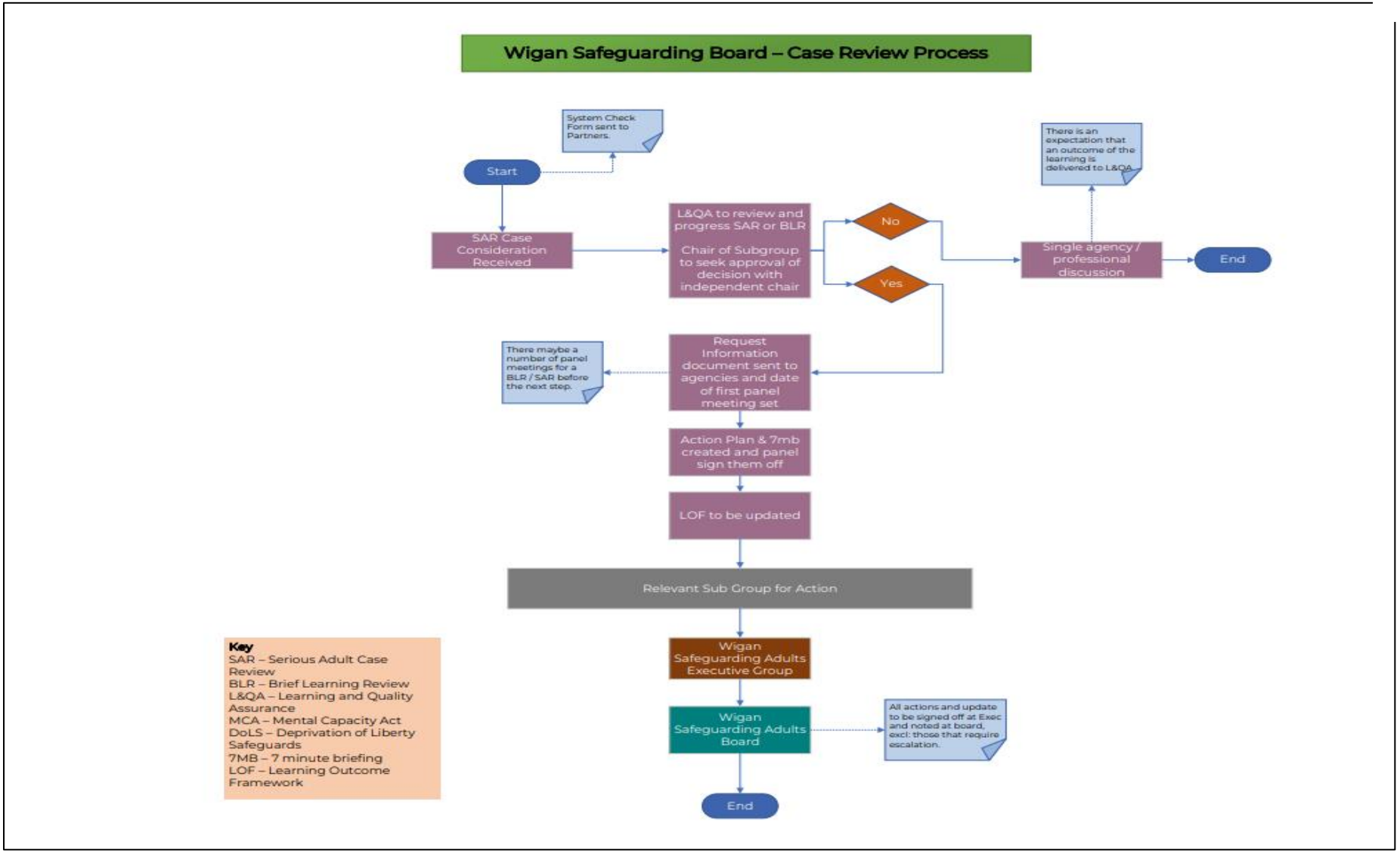
Follow up meetings / Action tracking:

The aim of a Review is, wherever possible, to complete the learning process in the single meeting and set actions. Actions agreed will be tracked by the WSAB Learning and Improvement Team in line with the timescales set and captured on the Learning Outcomes Framework (LOF). The LOF is not owned by one single agency or person and progression of actions is tracked through the various subgroups of WSAB and action statuses reported through each Board Meeting to ensure delays and escalations occur at the necessary level.

Ending the Process

A 7 Minute Briefing will be completed which will capture a concise history of the case, themes of the review and learning. These 7 Minute Briefings will be signed off through a final meeting of those involved in the meeting and then submitted to the next Learning and Quality Subgroup. Finalised reviews will be circulated and noted at the WSAB Executive Group and update to Board to ensure learning is shared among the partnership. Any associated action plans will be managed as noted above through the LOF process.

Appendix One – The Wigan Process



Appendix 2 Model Letter to Family

Safeguarding Adult Review

Your reference:
Please ask for:
Extension:
Direct line:
Date:

Dear [Recipient's Name],

A referral has been made to the Wigan Safeguarding Adults Board to undertake a Safeguarding Adult Review regarding the death of [Name]. I would like to extend my heartfelt condolences for your loss and apologise for any distress this review may cause. These reviews are conducted in accordance with the Care Act of 2014. Their primary aim is to identify any lessons about how local professionals and organisations worked, both individually and together, to safeguard [Name].

As part of this process, we will contact all relevant agencies, family members, and others who had contact with [Name] to gather information that might help explain what happened. Once this information is collected, a panel comprising the involved agencies will meet to consider whether anything could have been done differently to prevent [Name]'s death. An anonymised report will then be prepared.

As a family member, we are contacting you to see if you would like to contribute to the review. If you choose to participate, please contact me via phone or email using the details below. Please be assured that anything you share will be kept completely confidential and will only be used with your consent.

Yours sincerely

Appendix 3 SAR Case Consideration Referral / Report Form

SAR Case Consideration Referral / Report Form

Completed forms are to be returned securely to WSAB@wigan.gov.uk

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

2. Subject and Family Details *Please include known relatives and 'relevant others'*					
Name	DOB	Sex	Relationship	Address	Ethnicity

3. Event Details	
Type of Incident	

4. Chronology of Relevant Events (including your agency involvement and key contact details and details of other agency involvements, if known).

5. Please provide identified areas of concern for consideration of SAR