Isle of Wight Safeguarding Adults Board

Multi-Agency Learning and Review Framework

Learning from Experience to Improve Practice

The IOWSAB believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice. This Framework is designed to support these processes.

1. INTRODUCTION

The Isle of Wight Safeguarding Adults Board (IOWSAB) is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working to safeguard adults at risk. The Isle of Wight Safeguarding Adults Board has adapted the Learning and Review Framework created by the Hampshire Safeguarding Adults Board and is grateful to the Hampshire Board in allowing the IOWSAB to use their original framework document. It has been developed for use by all partner agencies and local organisations which work with adults at risk across the Isle of Wight. The IOWSAB is confident that the approaches outlined in the Learning and Review Framework will drive improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

Overview

The Learning and Review Framework recognises that IOWSAB member agencies and organisations have their own internal governance and learning structures. This Framework therefore, seeks to complement and build on single agency arrangements by adding a multi-agency approach to enable partner agencies to work collaboratively to learn lessons from cases where there may have been multi agency failings and to use this learning to improve future joint working. The Learning and Review Framework is designed to support decision making regarding the use of multi-agency review processes and outlines the pathway for commissioning reviews and the governance arrangements underpinning these arrangements.

Guiding Principles

The review and audit processes referenced in this Learning and Review Framework are underpinned by the following principles:

- Learning and review activities should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.

- Adults at risk and their families should always be offered the opportunity to contribute to the learning review and receive feedback on the learning outcomes achieved.

- Professionals from the range of agencies involved in the case should be fully engaged in the learning review and be invited to contribute their perspectives.

- The central focus of any learning review will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working.

- The learning review should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew or could have reasonably have been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.

- Learning reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and allows for reflection.

- The Care Act 2014 provides a statutory basis for undertaking the learning and review processes described in this Framework.

- This Framework recognises that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and the importance of managing the interface between these.

- Where the IOWSAB is satisfied that other review processes have adequately identified learning it may not be necessary to conduct a multi-agency review under this Framework in order to avoid duplication of activity.

- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a multi-agency review.

2. LEGAL AND POLICY CONTEXT

The Care Act 2014 comes into force in April 2015 and creates a new legal framework for Adult Safeguarding. Section 44 of the Act requires Safeguarding Adults Boards (SAB) to undertake a safeguarding adult review (SAR) in specific circumstances and places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt.

The law requires local SABs to arrange a 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 more effectively to protect the person at risk.

The SAB must also arrange a SAR when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. A separate Safeguarding Adult Review Policy has been produced which outlines the process to be followed in these cases.

The Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example. This Framework highlights a number of other review processes that could be used in these circumstances.

This Learning and Review Framework reflects and builds on the six safeguarding principles outlined in the Government's Statement on Adult Safeguarding published May 2013. These not only should be the basis upon which judgements are made about events and practice but also are the principles underpinning the review process itself. These principles are:

1. Empowerment Presumption of person led decisions and informed consent.

2. Prevention It is better to take action before harm occurs.

3. Proportionality Proportionate and least intrusive responses appropriate to risks.

4. Protection Support and representation for those in greatest need.

5. Partnership Local solutions through services working with their communities.

6. Accountability Accountability and transparency in delivering safeguarding.

3. ROLES AND RESPONSIBILITIES

The IOWSAB believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice.

Individual organisations will have their own internal governance systems and statutory or contracting requirements in respect of investigating or reviewing incidents. This Learning and Review Framework is not intended to duplicate or replace these but seeks to enhance and complement these arrangements. In relation to current single agency governance arrangements, the NHS is required to undertake Serious Incidents that Require Investigation Reviews (SIRIs) when specific criteria are met.

In addition to the SAR process, the Learning and Review Framework also provides other tools to enable partner agencies to reflect on and learn from cases which may not meet the criteria for a SAR but nonetheless have the potential for providing important learning with which to improve practice and partnership working.

Partner agencies and local organisations who work with adults at risk are invited by the IOWSAB to endorse this framework and going forward, to embed it in their internal governance processes as well as within their training policies.

The IOWSAB is supported by its Safeguarding Adult Review Sub-group in the implementation, management and oversight of the Learning and Review Framework and the activities linked to it. The Safeguarding Adult Review Sub-group is responsible for determining whether or not a review should take place (and if so, the most appropriate type of review to commission). It will also oversee the review process, the development of the action plan, and the publication of the report. It will be responsible for monitoring the implementation of any action plans arising from reviews and for ensuring that the impact of changes on the experiences and outcomes for service users are evaluated.

As part of the Learning and Review Framework the IOWSAB will develop a programme of learning workshops to explore a sample of cases in order to improve frontline practice and partnership working.

This framework covers a range of reviews and audits aimed at reducing future risk and driving improvements. The framework provides a mechanism to check that learning from serious case reviews, domestic homicide reviews, CQC investigations, etc. have led to changes and improvement at service delivery level. **Appendix A** outlines roles and responsibilities in the implementation of the framework.

4. ACTIVITIES TO SUPPORT LEARNING FROM EXPERIENCE

A. Safeguarding Adults Reviews (previously Serious Case Reviews)
B. Multi-agency partnership reviews
C. Multi-agency reflective workshops
D. Multi-agency themed audits

Referrals for a multi-agency review

This section outlines the process for making a referral for a multi-agency review. Following a serious incident, active consideration should be made as to whether or not a referral for a multi-agency review under the Learning and Review Framework is necessary. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

It is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (e.g. SIRI), this should take place as a matter of priority. Internal governance processes and multi-agency reviews are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes. Key questions to consider as part of internal processes include:

- Was the incident reported internally?
- Has an internal investigation been carried out?
- Has the investigation highlighted concerns about any other organisations?
- Has any information come to light indicating abuse or neglect as a contributory factor?
- Based on findings, are criteria for making a referral met?

The following considerations should be made when deciding whether to make a referral for a multi-agency review:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.

- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

Some cases referred may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children's serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

There may also be parallel processes in place such as a criminal investigation or coroner's inquest, which whilst not preventing a referral from being made, will need to be taken account of in terms of the timing and management of any subsequent multi agency review.

The family should be informed of the concerns and that a learning and review referral is planned and so providing an opportunity for them to give their view about the referral and to discuss how they might want to be involved.

If it is felt that the circumstances of the case may benefit from a multi-agency review, the organisation's IOWSAB representative and/or Safeguarding Adult Review Sub-group representative must be briefed on the case and notified of the intention to make a referral.

To make a referral for a multi-agency review, the referral form in **Appendix B** should be completed and submitted to the Safeguarding Adult Review Sub-group via the following email address: lsab@iow.gov.uk . The form should be password protected using a password that will be provided by the IOWSAB Manager on request of the referrer and will be case specific.

Each referral will be looked at by the Safeguarding Adult Review Sub-group. After consideration, the sub-group may contact involved agencies to request completion of a scoping chronology to inform decision making about next steps. **Appendix C** outlines the referral pathway and timescales.

If the case meets the criteria for a SAR, the Safeguarding Adult Review Sub-group Chair will make a recommendation to the IOWSAB Chair recommending that a SAR be commissioned. If the IOWSAB Chair agrees to commission a SAR, the review will follow the specific policy guidance written for such reviews as set out in the IOWSAB Safeguarding Adult Review Policy.

A SAR is a statutory process for cases meeting specific criteria. For cases not meeting these criteria, the IOWSAB Safeguarding Adult Review Sub-group may recommend to the IOWSAB Chair that another type of review be commissioned or decide not to commission any review at all. The following section provides guidance on the different types of review which may be considered.

A. Safeguarding Adult Review (SAR)

The Safeguarding Adults Board is the only body that can commission a SAR. Under Section 44 of the Care Act 2014, the SAB must arrange a 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 more effectively to protect the adult. The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. The adult who is the subject of any SAR need not have been in receipt of care and support services at the time.

Purpose

The purpose of a SAR is to:

- Determine what might have done differently that could have prevented harm or death.
- Identify lessons and apply these to future cases to prevent similar harm occurring again.
- Review the effectiveness of multi-agency safeguarding arrangements and procedures.
- Inform and improve future practice and partnership working
- Improve practice by acting on learning (developing best practice).
- Highlight any good practice identified.

Its purpose is 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

Criteria for a safeguarding adult review

The IOWSAB must arrange a SAR in the case of an adult in its area if:

1) The case involves an adult with care and support needs (whether or not the local authority was meeting those needs)

2) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

AND

3) The person died (including death by suicide) and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

4) The person is still alive but the SAB knows/suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

Process

- The Safeguarding Adult Review Sub-group will be responsible for establishing an independently chaired Safeguarding Adult Review Panel to undertake the review and will maintain an oversight and co-ordination role throughout the process.

- The SAR will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. A reviewer role profile has been developed to ensure appropriately experienced and skilled people undertake this role.

- The SAR will reflect the six safeguarding principles outlined on page 3.

- The IOWSAB Safeguarding Adult Review Sub-group will agree terms of reference and these will be published and openly available

- If the IOWSAB requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the SAB.

- When undertaking the SAR, the records will either be anonymised through redaction or consent should be sought.

- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a safeguarding adult review.

- Recommendations and action plans arising from the SAR will be monitored by the Safeguarding Adult Review Sub-group.

Reporting arrangements

The Safeguarding Adult Review Sub-group will provide regular updates to the IOWSAB on the progress of the review. The SAR will report within six months of the

SAR being established. Once completed, the report and recommendations will be presented to the IOWSAB for consideration. Once the report is approved, the Safeguarding Adult Review Sub-group will produce a multi-agency action plan responding to any recommendations made. Monitoring of the implementation of the action plan will be undertaken by the Safeguarding Adult Review Sub-group.

The norm will be to publish an anonymised version of the full report on the IOWSAB website. In exceptional circumstances however, this practice may vary. As a means of signing off the SAR process and its resulting action plan, involved agencies will be asked to complete an impact analysis report detailing the outcomes and difference made as a result of the actions undertaken. Collated findings from the review will be included in the IOWSAB Annual Report.

B. Multi-Agency Partnership Reviews

A multi-agency partnership review will be commissioned by the IOWSAB Cahir through the Safeguarding Adult Review Sub-group but will be led by the organisations involved.

Purpose

The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved.

Criteria

Multi-agency reviews will be considered where an adult at risk has died unexpectedly or sustained serious injury or harm and/or where there were safeguarding concerns identified prior to the incident or as a result. This may include circumstances where self-neglect may have been a factor and also where an adult with needs of care and support has died as a result of fire and there may have been opportunities for the agencies involved to identify risk factors and to develop a risk management plan to manage these. This form of review can be used for cases falling short of SAR criteria and any of the following criteria can also be applied:

- The person was receiving services from more than one agency at the time of the incident
- The service user was under formal safeguarding procedures at the time of the incident
- Multi-agency concerns or learning has been identified
- The incident arose from or occurred during the delivery of care

Process

- Supportive partnership working should be maintained throughout the process.
- A review team will be set up consisting of representatives of the agencies involved.
- The lead co-ordinating agency will be agreed and this agency will be responsible for arranging and chairing meetings as well as drafting the review report. Terms of reference will be agreed jointly at an initial scoping meeting.
- Each review team member will review their practice against expected organisational standards by interviewing staff, reviewing records and referring to organisational policies and procedures.
- The review team will share their own organisational findings with each other and will produce a report jointly agreed by agency representatives, covering both single agency and multi-agency responsibilities.

Reporting arrangements

- Reporting will be via internal individual organisations usual governance arrangements.
- In addition, reporting will be through IOWSAB Safeguarding Adult Review Sub-group who will include collated findings in an annual learning report to the IOWSAB.

C. Multi-Agency Reflective Workshops

A multi-agency reflective workshop will be commissioned by the IOWSAB Chair through the Safeguarding Adult Review Sub-group but led by the organisations involved.

Purpose

The purpose of this type of review is for agencies involved with an incident to meet together and share their perspectives as a self-assessment of the multi-agency safeguarding arrangements and practice and to identify improvements.

Criteria

A reflective workshop should be undertaken in the event of an adult at risk experiencing harm and where there are limited concerns about how organisations or professionals worked together but where the outcome for the adult(s) involved was

poor. The issue may have come to attention due to a complaint or a concern raised. These reviews should be commissioned where it is believed there is potential learning and the possibility of improvements in the system to be made.

Process

The workshop will involve a one off facilitated event involving practitioners and managers directly involved in the case or in some circumstances other representatives such as those in policy or strategic roles who may be able to contribute to the learning process and/or in supporting implementation of learning into practice. The aim of the activity is to make a positive impact on frontline practice.

The focus of the workshop will be to reflect on the adult's journey through the system to identify any opportunities for improved interface between agencies. The workshop will be facilitated by people independent of the case or the organisations involved.

Reporting arrangements

As an outcome of the workshop a series of actions or recommendations will be agreed by the attendees. Delegates will be responsible for providing feedback on generic areas of learning to their respective senior management teams and to relevant operational teams. These will also be shared with the IOWSAB Safeguarding Adult Review Sub-group. Partner agencies' IOWSAB representatives should be involved in any action planning within their organisation around the recommendations highlighted (as relevant to their organisation). The agencies involved in the review will be asked to provide IOWSAB with an impact analysis report outlining actions taken by their organisation to improve practice and partnership working in response to the case. Thematic findings from the reviews will be collated on an annual basis and a summary included in the IOWSAB Annual Report.

D. Multi-agency Themed Audits

Purpose

The purpose of multi-agency themed audits is to audit practice across agencies relating to a specific topic of interest. They yield qualitative information enabling the IOWSAB and partner agencies to test out the effectiveness of the system following changes in policy or guidance or it may be in order to understand why a particular group are more at risk or to evaluate the scale of an emerging problem area in order to seek to address it. These will be commissioned by the IOWSAB Safeguarding Adult Review Sub-group but will be overseen by the IOWSAB Quality Assurance and Performance Sub-group. Audit activities will form part of the IOWSAB Annual Audit Programme.

Criteria

Multi-agency themed audits can be undertaken on any topic or themes where concerns are identified that suggest a particular group may be more at risk. Examples might include undertaking a multi-agency audit on responses to financial abuse to test out any blockages in the system or check how agencies are working together.

Process

The programme will be agreed annually by the IOWSAB and will be co-ordinated and managed by the IOWSAB Quality Assurance and Performance Sub-group. The programme will be informed and influenced by an inter-play of four key factors:

- Issues and themes emerging from local safeguarding monitoring information
- Patterns and trends in local cases referred for learning and review
- IOWSAB priorities
- Response to national developments and events

The audits will normally be undertaken by a multi-agency audit team working to agreed terms of reference. A report outlining findings and recommendations will be produced and a multi-agency action plan developed to address these. The Quality Assurance and Performance Sub-group will be responsible for monitoring implementation.

Reporting arrangements

The audit report will be shared with the IOWSAB and more widely with partner agencies.

5. LEARNING INTO PRACTICE

In order to improve safeguarding practice learning identified from reviews and audits of practice must be considered operationally and strategically so that changes to policy and practice can be taken forward.

Embedding Learning

Embedding learning is achieved by disseminating learning and taking actions as a response to improve practice by:

Dissemination of Learning

What	Responsibility	Reporting to IOWSAB
Multi-Agency Training Programme	IOWSAB Training Sub-group Partner agencies Relevant organisations	IOWSAB Training Sub-group
IOWSAB 'Learning Lessons' Workshops	IOWSAB Manager IOWSAB Training Sub-group	IOWSAB Training Sub-group
IOWSAB briefings and communication strategy	IOWSAB Manager IOWSAB Partner agencies Relevant organisations	IOWSAB Manager
Publication and dissemination of SAR final reports	IOWSAB Partner agencies Relevant organisations	IOWSAB Safeguarding Adult Review Sub-group
Single agency training	All agencies	All agencies
Single agency briefings and other communication strategies	All agencies	All agencies

Actions to Improve Practice

What	Responsibility	Reporting to IOWSAB
Implementation of single and multi-agency action plans from themed audits, multi-agency partnership reviews and reflective workshops	Relevant agencies	Relevant agencies via IOWSAB Safeguarding Adult Review Sub-group
Monitoring of single agency action plans	IOWSAB Safeguarding Adult Review Sub-group	IOWSAB Safeguarding Adult Review Sub-group
Monitoring of action plans from SARs	IOWSAB Safeguarding Adult Review Sub-group	IOWSAB Safeguarding Adult Review Sub-group

Evaluating Learning

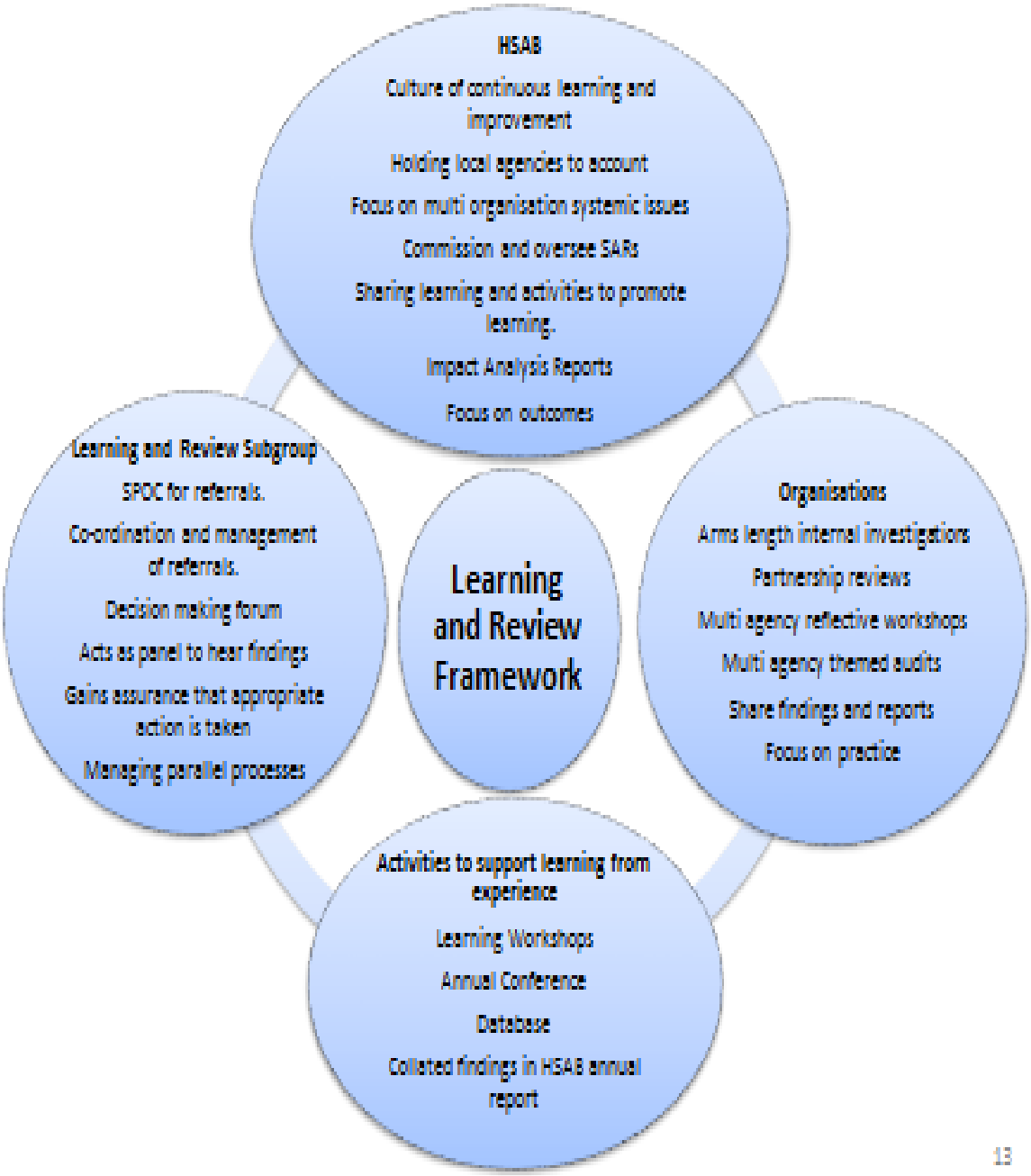
As part of its quality assurance activity IOWSAB evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

How	Who	Reporting to IOWSAB
Follow up single and multi-agency case audits	Partner agencies Relevant organisations	IOWSAB Quality Assurance and Performance Sub-group
Reporting on multi-agency and single agency action plans	Partner agencies Relevant organisations	IOWSAB Quality Assurance and Performance Sub-group
Evaluation of training	Workforce development course participants	IOWSAB Training Sub-group
Surveys and questionnaires	Relevant agencies with oversight from IOWSAB Quality Assurance Subgroup	IOWSAB Quality Assurance and Performance Sub-group
Impact evaluation reports of the difference made on service users experiences and outcomes	Relevant agencies	Relevant agencies
Annual report of collated findings and analysis of the range of review activities undertaken throughout the year.	IOWSAB Manager	IOWSAB Safeguarding Adult Review Sub-group

6. MONITORING AND REVIEW

This framework will be monitored by the IOWSAB Safeguarding Adult Review Sub-group and will be reviewed on an annual basis or sooner in response to the delivery of this framework or changes in national policy or guidance. The IOWSAB Safeguarding Adult Review Sub-group will also produce an annual report for IOWSAB of collated findings and analysis of the range of review activities undertaken throughout the year.

Appendix A: Roles and Responsibilities



13

APPENDIX B:

Safeguarding Adult Review or Child Serious Case Review

Referral Form

The criteria for the respective Safeguarding Board to commission a Safeguarding Adult Review or a Child Serious Case Review are as follows:-

Safeguarding Adult Review (Section 44 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).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

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

(b) Applying those lessons to future cases.

Child Serious Case Review (Chapter 4 Working Together March 2015)

Regulation 5 (2) of the Local Safeguarding Children Boards Regulations 2006 sets out the criteria for when a LSCB is required to undertake a review into a serious case. A serious case is defined as one where:

(a) Abuse or neglect of a child is known or suspected;

AND

(b) Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

PART 1.

1. Referral Details

Referrer's Name & Role	
Agency	
Tel. No.	
Email	
Date of Referral	
State if referral is for IOW LSAB or IOW LSCB	
Details of any other review or investigation e.g. SIRI, mental health review, criminal investigation, SFO review, MAPPA review, DHR, YOT review etc.	

2. Details of Subject (add additional table for each additional subject)

Full Name	
Any Aliases	
Date of Birth	
Date & Cause of Death (if applicable)	
Ethnicity	
Gender	
Address	
School / Nursery / Residential Home / Care Home etc. (if applicable)	

3. Details of Significant Person e.g. parent, carer, sibling, son, daughter etc. (add additional table for each additional significant person)

Full Name	
Any Aliases	
Date of Birth	
Relationship to Subject	
Address	

4. Agencies Involved with Subject (please tick)

Adult Mental Health		Health	
Adult Social Care		Hospital	

Ambulance		LA Education Service	
CAMHS		Police	
Children's Social Care		LA Regulatory Services	
College		Probation	
CRC		Residential Home	
Drug / Alc Services		School	
Fire & Rescue		YOT	
G.P		Other (specify)	

5. Reasons for Referral
(Refer to SAR and SCR criteria on Page 1)

(a) Reasons for Referral for Safeguarding Adult Review (please tick)

Adult with needs for care and support	
Concern about multi agency working	
Adult has died AND death linked to abuse or neglect	
Adult is alive having experienced serious abuse or neglect	
Other reason (specify)	

(b) Reasons for Referral for Child Serious Case Review (please tick)

Abuse or neglect of a child is known or suspected.	
A child has died (including suicide)	
A child has been seriously harmed	
Concern about multi agency working	
Other reason (specify)	

6. Characteristics of Case

Domestic abuse		Alcohol abuse		Drug abuse	
Mental health		Fabricated illness		Shaken baby	
Sexual abuse		Looked after child		Sexual exploitation	
Emotional abuse		Neglect		Physical abuse	
Self-neglect		Homelessness		Abusive head trauma	
Hidden adults		Financial abuse		Overlay	
Disability		Chronic illness		Learning difficulties	
Self-harm		Suspected suicide		Cross border issues	
Abuse by person in position of trust		Section 47 investigation		Section 42 Care Act procedures	
Human trafficking		LGBT issues		Forced marriage	
Child Protection Plan					
Other (specify)					

7. Case Outline

Please give a summary of the circumstances of this case and explain why you feel this case should be considered for a safeguarding adult review, child serious case review, single agency review, or multi-agency/partnership review.

When completed please send this referral form as a password protected document to one of the following addresses**:**

For a Safeguarding Adult Review Referral please e-mail to the IOW LSAB Partnership Support Team: **rachel.watson@iow.gov.uk**

For a Child Serious Case Review Referral please e-mail to the IOW LSCB Partnership Support Team: **LSCB@iow.gcsx.gov.uk**

PART 2.

For Completion by Partnership Support Team

Action	Details	Date
Recommendation of LSAB SAR sub-group or LSCB LIG sub-group (include rationale for the recommendation, whether the recommendation is unanimous or majority, type of review recommended)		
Decision of LSAB or LSCB Chair		
Confirmation that referrer has been informed of outcome.		
Notification to National Panel (for child reviews only)		
Response from National Panel (for child reviews only)		

APPENDIX C: Multi Agency Review Referral Pathway

Isle of Wight Safeguarding Adults Board Case Review Process

Incident/case situation

Discuss with senior manager and SAR group member

STAGE 1: NOTIFICATION AND CONSIDERATION

Referral to SAR Group

- Complete referral form and submit to IOWSAB Business Unit
- Board manager/referrer initial discussion if required
- Scoping template sent out to agencies by Business Unit
- Agencies submit the scoping form to the Business Unit

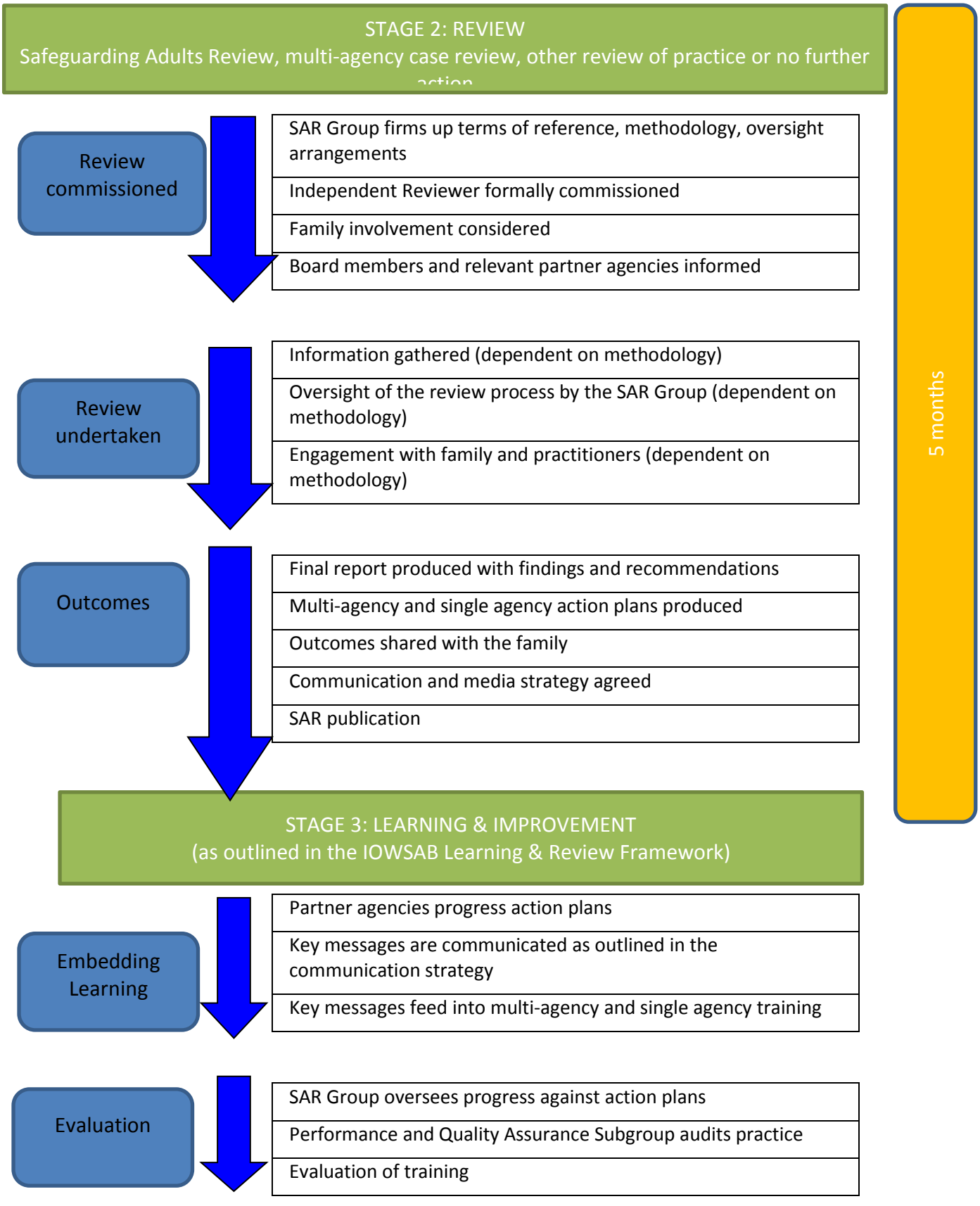
SAR Group

- Agency SAR Group member presents case
- Information reviewed
- Recommmendation to the IOWSAB Chair on:
  1. Whether the criteria for a SAR is met
  2. What form of case review should be undertaken
  3. Initial proposal for terms of reference and methodology
- SAR Group Chair writes to the IOWSAB Chair with recommendations

IOWSAB Chair Decision

- Criteria, review, Terms of Reference and methodology
- Independent Chair writes to the SAR Subgroup with their decision
- Notification to Board members and partner agencies

1 month


STAGE 2: REVIEW
Safeguarding Adults Review, multi-agency case review, other review of practice or no further action
Review commissioned
SAR Group firms up terms of reference, methodology, oversight arrangements
Independent Reviewer formally commissioned
Family involvement considered
Board members and relevant partner agencies informed
Review undertaken
Information gathered (dependent on methodology)
Oversight of the review process by the SAR Group (dependent on methodology)
Engagement with family and practitioners (dependent on methodology)
Outcomes
Final report produced with findings and recommendations
Multi-agency and single agency action plans produced
Outcomes shared with the family
Communication and media strategy agreed
SAR publication
5 months
STAGE 3: LEARNING & IMPROVEMENT
(as outlined in the IOWSAB Learning & Review Framework)
Embedding Learning
Partner agencies progress action plans
Key messages are communicated as outlined in the communication strategy
Key messages feed into multi-agency and single agency training
Evaluation
SAR Group oversees progress against action plans
Performance and Quality Assurance Subgroup audits practice
Evaluation of training