Peterborough
Safeguarding Adult Review
Policy and procedure

March 2015

Version Control:

Version	Date	Author/Reviewer	Comments
V2	18/01/2017	Angela Harbour	Page 4 – The following has been added to the end of the 6th bullet point: All agencies must consider, throughout their investigation, whether the aforementioned processes are applicable to one or more members of staff within their organisation. This considration must be recorded.

1. INTRODUCTION

This document sets out the Peterborough Safeguarding Adult Board's (PSAB) policy and procedures for instigating and conducting Safeguarding Adult Reviews (SAR). These are now a statutory requirement as part of the Care Act 2014.

2. BACKGROUND

The document 'No Secrets'[1] (March 2000) issued by the Department of Health and Home Office under section 7 of the Local Authority Social Services Act 1970, gave guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

The document Safeguarding Adults published by the Association of Directors for Social Services (ADASS) in October 2005 provides a National Framework of Standards for good practice and outcomes in adult safeguarding work. One of the standards in this document states that as good practice, Adult Safeguarding Boards should have in place a serious case review protocol.

The PSAB adheres to both these sets of guidance and has been for some time using procedures to review cases where abuse or neglect may have occurred and where agencies could have done more to protect that adult from the abuse. These established procedures have placed the PSAB in a good place to comply with the requirements of the Care Act 2014. The procedures set below are fully Care Act compliant.

3. SAFEGUARDING ADULT REVIEWS (SAR)

3.1 Purpose

The purpose of a SAR is not to reinvestigate or to apportion blame.
It is:

- to establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard vulnerable adults;
- to review the effectiveness of procedures;
- to inform and improve local inter-agency practice and
- to improve practice by acting on learning (developing best practice)

It is the responsibility of the SAR Sub-Group of the PSAB to ensure that all agencies have their own internal/statutory procedures to investigate serious incidents; this protocol is not intended to duplicate or replace these. In certain situations where there is either a serious incident investigation or a domestic homicide review or a child SCR under consideration, discussions between each lead agency will be required to avoid duplication of effort and best use of resource.

The SAR sub-group will adopt a position of transparency with regard to all information shared as part of the investigatory proceedings. A report and associated action plan will be published at the conclusion of the review.

3.2 Criteria

The Care Act 2014 statutory guidance describes the below criteria and process to be followed. This is the procedure the PSAB are following.

[1] No Secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse Department of Health 2000.

1) SABs 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.

2) SABs 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.**

In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

SARs carried out by the PSAB will reflect the six safeguarding principles.

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."
- **Prevention** – It is better to take action before harm occurs.
"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."
- **Proportionality** – The least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."
- **Protection** – Support and representation for those in greatest need.
"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."
- **Accountability** – Accountability and transparency in delivering safeguarding.
"I understand the role of everyone involved in my life and so do they."

The Terms of Reference for any SAR will be agreed by the PSAB SAR sub-group.

When undertaking SARs the records will either be anonymised through redaction or consent will be sought.

The following **principles** are applied by the PSAB and their partner organisations to all SAR reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. 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. All agencies must consider, throughout their investigation ,whether the aforementioned processes are applicable to one or more members of staff within their organisation. This considration must be recorded.
- It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.
- No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR will be followed through by the PSAB.
- The PSAB ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and, or, their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

It is expected that those individuals that will undertake a SAR for the PSAB will have appropriate skills and experience which should include:

- Strong leadership and ability to motivate others;
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- Collaborative problem solving experience and knowledge of participative approaches;
- Good analytic skills and ability to manage qualitative data;
- Safeguarding knowledge and
- Able to promote an open, reflective learning culture.

The PSAB will aim for completion of a SAR within a reasonable period of time and where possible within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

3.3. Commissioning a Safeguarding Adult Review

The PSAB will be the only body, which commissions a Safeguarding Adult Review. The Independent Chair has final responsibility for the decision to initiate a SAR following a recommendation from the SAR Sub-Group. Any agency or other interested party may request that the PSAB consider a SAR through a discussion with the Safeguarding Adults Co-ordinator (see appendix A for referral form).

In the event of a referral being turned down, the reasons will be recorded in writing and fed back to the referrer.

3.4 The Safeguarding Adult Review Process

The SAR subgroup will be made up of the following representatives:

- Chair of PSAB
- Representative of Adult Social Care Peterborough
- Representative of Cambridgeshire & Peterborough Foundation Trust
- Representative of Peterborough and Stamford Hospitals NHS Foundation Trust
- Representative of Cambridgeshire Constabulary
- Representative of Clinical Commissioning Group
- Representative of United Care Partnership – who must have clinical and Community Services experience

It will be supported and advised by:

- Safeguarding Adults Strategic Lead
- Safeguarding Adults Coordinator
- Representative of Peterborough City Council Legal services

Other members may be co-opted as required.

An initial meeting will agree:

- the terms of reference
- which agency should provide a chronology and IMR (see appendix for guidance)
- the support and other resources, including budgetary, needed
- who will write the Overview Report (see appendix for guidance)
- timescales within which the review process should be completed
- dates, times and venues of meetings
- the nature and extent of legal requirements, in particular: Data Protection, Freedom of Information and the Human Rights Act
- whether additional members of the panel are needed, depending on the nature of the SAR
- whether expert advice is needed on any aspect of the SAR
- how members of the family should be involved in the process
- the links with any other investigations e.g. inquest, criminal proceedings
- whether any particular equality and diversity issues relate to this case

On receipt of the each agency's individual management review (IMR), the SAR Sub-Group, together with the overview report writer, will undertake an "information sharing" session where agencies will present their reports. The PSAB will provide an integrated chronology.

Significant issues will be identified and clarified. Further additional information will be requested and the terms of reference amended if necessary

The Overview Report writer will ensure that:

SAR reports:

- provide a sound analysis of what happened, why and what action needs to be taken to
- prevent a reoccurrence, if possible;
- be written in plain English; and
- contain findings of practical value to organisations and professionals
- summarise the facts of the case
- review, cross-reference and analyse all agency management reports and information gathered from any other source
- identify recommendations
- form a view on practice and procedural issues

If at any stage of this procedure, information is received which requires notification to a statutory body regarding significant omission by individual/s or organisations this should be done via the chair of the SAB without delay.

On completion, the Overview Report will be presented to the SAR Sub-Group, which will:

- ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report
- ensure that the Overview Report can be published
- translate recommendations from the Overview Report into an action plan, which should be endorsed at senior level by each agency
- agree the means of monitoring and reviewing intended improvements in practice and/or systems
- clarify to whom the report or parts of the report should be made available and agree the means by which this will be carried out
- consider any cross border issues
- decide how the family should be informed of the outcome of the review

The action plan will indicate:

- who will be responsible for various actions
- timescales for completion of actions
- the intended outcome of the various actions and recommendations

Findings from SARs- the role of the PSAB

- On completion of the overview report, the executive summary and action plan will be presented to the PSAB for comment and approval.

- The PSAB should include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take in relation to those findings.

- Where the PSAB decides not to implement an action then it must state the reason for that decision in the Annual Report.

- All documentation the PSAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

- The PSAB will decide the frequency with which progress on the implementation of the action plan is reported to the Board.

- Following sign-off by the Board, the executive summary and the associated action plan will be published on the website and the lessons learnt disseminated to relevant staff
- Consideration will be given to whether or not it is appropriate to publish the overview report.
- Media involvement will be planned

5.0 Single Agency Reviews

On consideration of a referral for a possible SAR, the sub-group may decide that the issues relate to a single agency. Consequently, instead of commissioning a SAR the sub-group could request a single agency review of safeguarding practice.
Similarly, individual agencies already have a variety of internal processes for reviewing cases. There can be valuable lessons for other agencies arising from agency reviews such as serious incident investigations. When an agency is conducting an investigation involving a safeguarding issue, the SAR sub-group should be advised of this so as to enable them to assess whether there may be transferrable learning for partner organisations.

Links with other reviews

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example when considering whether some aspects of the reviews can be commissioned jointly, this is so as to reduce duplication of work for the organisations involved.

In setting up a SAR the Sub-Group will consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SCR or DHR, a criminal investigation or an inquest.
When completing a SAR and DHR or child SCR in parallel it will be established at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. The SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the PSAB to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

6. ANNUAL REPORT

All Safeguarding Adult Reviews conducted within the year should be referenced within the annual report along with any relevant service improvements.

7. OTHER CONSIDERATIONS

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005.
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established.
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'.
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act 1998, Children Act 1989 – updated 2004.

APPENDIX A

REFERRAL TO PETERBOROUGH SAFEGUARDING ADULT REVIEW SUB-GROUP, REQUESTING A SAFEGUARDING ADULT REVIEW.

The format for requesting a Safeguarding Adult Review should include the information listed in the form below.

All referrals will be considered by the Safeguarding Adult Review Sub-Group when it next sits. If the matter appears to require urgent attention then it will be sent directly to the Independent Chair of the Safeguarding Adult Review Sub-Group, who will decide if the Sub-Group needs to be convened as a matter of urgency.

Content of the referral

Safeguarding Adults Review Referral Form

The PSAB Safeguarding Adults Review Sub-group considers every referral on the basis of whether it meets the criteria for a Safeguarding Adults Review (see Section 3.2 PSAB Safeguarding Adults Review Policy)
The Sub-group needs as much information as possible to enable members to make a proportionate decision as to how to respond to a case referral, ensuring, if the case is accepted for a review, that that maximum learning is achieved for the PSAB. Please therefore complete as much information on this form as possible. This may be sent by secure e-mail to Angela Harbour (Safeguarding Adults Coordinator) – angela.harbour@peterborough.gcsx.gov.uk and telephone her to say you have sent it – 01733 452442.

i. Referrer

Name:	
Title:	
Agency (where applicable):	
Address:	
Telephone number:	
Email address:	

ii. Senior Manager Authorisation (where applicable)

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

iii. Adult who died or at Risk and Person(s) or Organisation(s) involved in the Harm or Neglect

i. Adult who died or at Risk	
Name:	
Date of birth:	

Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
Agencies involved:	

ii. Person(s) or Organisation(s) involved in the Harm or Neglect

Name:	
Date of birth:	
Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
Agencies involved:	

iv. Referral reason(s)

How does this case meet the criteria for a Safeguarding Adults Review? (See PSCB Safeguarding Adults Review Policy 2015. Please explain against criterion).	
What learning do you think can be achieved through review of this case?	
Which agencies / services are / were involved in this case?	
Which agencies / services should particularly achieve this learning?	
What other learning / review processes have been followed? (please detail) **What did they achieve? (please detail)** **How has that learning been disseminated? (please detail)** **What impact has it had? (please detail)**	

Please detail any other relevant information that will enable the Safeguarding Adults Review Sub-group of the PSAB and the Independent Chair to reach a decision about how to respond to this referral.	

APPENDIX B

INDIVIDUAL MANAGEMENT REVIEWS (IMRs) AND REPORTS BY MEMBER AGENCIES AND INDEPENDENT ORGANISATIONS

1. When a case meets the criteria for conducting a serious case review (see Section 3 of this process), the Chairperson of the Peterborough Safeguarding Adults Board will formally request the agencies to conduct an IMR of their involvement with the adult, the service and/or their family and to submit a report and recommendations arising from that review. The review should comply with the serious case review's terms of reference (which will be sent with the request) and guidelines contained in this Appendix.

2. The request for an IMR will be addressed to the chief officer or chief executive of the agency concerned. Although the task of completing the review may be delegated to a suitably qualified and experienced senior manager within the agency, it is important that the review is fully endorsed by a senior executive officer before submission to the SAR Sub-Group.

3. An IMR should only be undertaken by a manager who has not had immediate line management responsibility for any aspect of the case.

4. On receipt of the Peterborough Safeguarding Adult Board Chairperson's request, it is recommended that agencies should take action to secure all relevant records relating to the case to guard against loss or possible interference.

5. The aim of the IMR is to look openly and critically at both individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, identify what these changes are and how those changes will be brought about. It is important to consider why something happened as well as what happened.

6. The SAR, to which the IMRs contribute, is not part of the disciplinary inquiry or process. However, information that emerges in the course of reviews may indicate that disciplinary action should be taken under established agency procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases (e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard other appropriate adults.

7. The following IMR resource pack should guide the preparation of an Individual management review. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues which need to be explored, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of those particular circumstances.

8. Report writers should interview relevant staff as part of the process. When staff or others are interviewed, a written record of such interviews should be made and this should be shared with the relevant interviewee.

March 2015

Individual Management Review

Resource pack for Authors

Introduction

This resource pack is to provide guidance and support for Individual Management Review authors who have been commissioned to write an Individual Management Review (IMR) for a Safeguarding Adult Review (SAR) on behalf of their agency.

When submitting an IMR on behalf of your agency, please remove the introductory pages

CRITERIA FOR APPOINTING AN INDIVIDUAL MANAGEMENT REVIEW (IMR) AUTHOR

"Who should conduct Reviews?"

Each relevant service should undertake a separate Individual Management Review of its involvement with the service user. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual agency. Relevant independent professionals (including GPs) should contribute reports of their involvement.

a) You must appoint as your Author a person of sufficient seniority to be able to work at all levels within your agency. The Author must be fair in the way that the views of staff are represented. The Author you appoint should be familiar with current safeguarding adult's procedures and is expected to produce an independent and objective report within prescribed timescales in accordance with national guidance.
b) The Author will have had no significant involvement in the case under review and should not be in the direct line manager of their agency representative on the Safeguarding Adult Review Panel.
c) The Author prepares the report for your agency and is accountable to the Senior Executive for the quality of the report. The report is submitted as an agency report.
d) The Author acts as the representative for your organisation in its interface with the Safeguarding Adult Review Panel.
e) The Author should have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the Author will wish to interview staff who are central to the case. Staff who wish to be interviewed should be offered this opportunity by the Author. Such interviews should be allowed.
f) The Author must ensure that the relevant staff of your agency are informed of the purpose of the Individual Management Review and the process leading to the Safeguarding Adult Review.
g) The Author should ensure that all files relating to the service user are secured, preferably under lock and key, to ensure information is not lost. The Author should be empowered to demand appropriate security measures are taken. If the case remains open then a full copy of the file should be taken and the original file secured. All files should be made available to the Author.

h) The Author shall identify and indicate the location of all files relating to the service user and make these files available to the Chairperson of the Safeguarding Adults Review Panel on request.
i) The compilation of the Individual Management Review report will create a significant extra workload. It is important that agencies support members of their staff who are required to contribute to Safeguarding Adult Reviews. The Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the Individual Management Review report within the strict time scale. The Author should receive appropriate clerical support throughout. You will appreciate it may be necessary for the Author to be relieved of all their normal duties for the period the Individual Management Review report takes to compile.

Appropriate extracts of the Individual Management Review should be shared with workers involved with the case to ensure the report is factually correct prior to submission.

Timescales for the Safeguarding Adult Review have already been set and senior managers from all agencies are represented. If your Individual Management Review report is not received within the prescribed timescale, the work of the panel cannot proceed. This will result in the PSAB having to specify to why the report has been delayed further.

Please note, undertaking an IMR is time consuming. It is important that IMR Authors leave adequate time in their diary's to complete all the commitments. It might be that due to unforeseen circumstances they are asked at short notice to attend a meeting or provide further information.

Before you go any further, it would be wise to check whether the author is the right person to be producing an IMR. Please consider the following questions:

1. Is the author a manager or a person in a position of seniority who has not line managed/supervised any of the staff involved in the case?
2. Does the author have the level of experience and knowledge to be able to critically analyse the work, systems, policies and procedures of your agency in relation to safeguarding adults at risk of abuse?
3. Is the author fully independent of the staff or services involved in the case?

If the answer is "yes" to these questions, then the criteria has been met to be the author for an IMR. If the answer to any of these questions is "no" or if you have any other concerns about your suitability to author an IMR for a Safeguarding Adult Review, please speak to your own line manager, or seek advice from the Safeguarding Adults Strategic Lead.

Please contact Angela Harbour, the Safeguarding Adults Coordinator if further clarification is required.
Tel: 01733 452442
Email: angela.harbour@peterborough.gov.uk

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INDIVIDUAL MANAGEMENT REVIEW REPORT

It is compulsory for IMRs from all organisations to include ALL of the headings in **bold** below. If there is no information or the heading is not applicable, please state this and do not delete any headings

Safeguarding Adult Review in respect of	
Date of Birth	
Date of Death or serious incident Delete as appropriate	
Author of IMR	Insert Name and Designation of IMR Author here
Agency	Name of agency
Date of submission	Date the first IMR was submitted to PSAB business office or panel
Version	Version submitted (if applicable)

GUIDANCE: Please ensure that the countersigning person has seen the IMR at each submission stage

TABLE OF CONTENTS

1. Introduction

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The SAR sub-group will adopt a position of transparency with regard to all information shared as part of the investigatory proceedings. An executive summary report and associated action plan will be published at the conclusion of the review.

2. About the Author

The statement of Independence should contain the following information:

- Qualifications
- Experience
- Role in the agency
- Independence of the case

It should provide information about the author (name, job title etc.) and must provide a clear statement that illustrates their level of independence from the line-management of, and supervision of staff involved in the case.
It should clearly describe the sources of information used to prepare the IMR (e.g. analysis of case records, interviews with staff etc.) and when and by whom these were secured.

3. Terms of reference / Scope including time-frame to be covered

The Terms of Reference will be sent with the request for an IMR. Please ensure your report reflects the TOR.

4. Contextual Information

In considering this aspect of the case, you need to decide whether the context in which the case was conducted impacted on decisions made and if so, such information need only be included in so far as it is relevant to the actions of the organizations concerned.
Most weight should be given to primary information, although secondary and anecdotal information can be considered, but clearly identified as such and given less weight.
The type of information that would be useful is as follows:

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organizational change
- Unallocated cases
- The social and community context
- Management and Supervision
- Safeguarding Audit practices
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal Advice

This is not an exhaustive list and there may be other contextual factors that you would wish to include.

5. Methodology

A bullet point list to identify: -

a) How the agency carried out the review.

b) Details of documents seen. (at Appendix B)

c) List of interviews with staff and dates (at Appendix C)

d) Details of information not available/not considered (with reasons).

e) Details of staff involved by initial and job title for the benefit of the SCR Panel only. The overview report will be completely anonymised.

f) Were you given sufficient time to complete the tasks?

6. Summary of Facts

Begin your report with a summary of relevant historic information.
Construct a relevant summarised chronology (in narrative form) on the service user and any significant others which could have a bearing on the case and time frame under review. Briefly summarise decisions reached, the services offered and/or provided to the service user and other action taken.
This is not intended to be a repeat of the chronology, but will provide a summary of the information to add a context to the analysis contained within the next section of your report.

7. Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why something either did or did not happen. **In addition to the case specific terms of reference provided ensure you consider the following (if not already highlighted)**

- Were practitioners aware of and sensitive to the needs of adults at risk of abuse in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about an adults at risk of abuse?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of adults at risk of abuse and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the adult at risk? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the adults at risk and their family, and were they explored and recorded? This must be referred to.
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the PSAB's policy and procedures for safeguarding adults at risk of abuse and with wider professional standards?

- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

8. What are the learning points from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of adults at risk of abuse? Is there good practice to highlight, as well as ways in which practice can be improved?
Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?

9. Recommendations

Recommendations in IMRs should pertain to your agency, as well as to inter-agency practice. These must be SMART (Specific, Measurable, Achievable, Realistic and Timely) and should include:-

a) What changes (if any) could be made to your agency's Safeguarding Adults procedures?

b) What changes (if any) could be made in inter-agency working in the light of this case?

c) What action within your agency should be taken in the light of its findings?

d) What areas of good practice are there? Could these be expanded?

e) What action should be taken by whom and by when?

f) What outcomes should these actions bring about?

g) How will your agency review whether they have been achieved and its impact?

Please identify, after each recommendation, the paragraph numbers which contain the analysis leading to the recommendation.

(For Example:
Recommendation 1. Amend recording policy to clarify expectations in respect of case discussions with senior managers.
What action should be taken by whom and when?
What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?
Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

Signatures required on completed report

Author of IMR and Position	Senior Officer and Position within Agency
Date:	**Date:**

Appendix A - Action Plan

PETERBOROUGH SAFEGUARDING ADULTS BOARD

(Agency Name) - ACTION PLAN

FOR

D.O.B

D.O.D

RECOMMENDATION	ACTION	RESPONSIBLE OFFICER (NAME AND JOB TITLE)	DATE DUE TO BE COMPLETED	RECOMMENDATIONS FOR MONITORING AND REVIEWING IMPACT ON PRACTICE	EVIDENCE OF COMPLETION	DATE OF AGENCY SIGN OFF	DATE OF PSAB CHALLENGE FOR NON-COMPLETION / IMPACT (IF APPROPRIATE)

APPENDIX B – IMR Chief Officer's Statement.

Name/subject of Safeguarding Adult Review
Date of Birth:
Date of Death:
Agency Providing the Report:
Report Author and position:

Evaluation Statement on behalf of agency:

I am satisfied that:

- The IMR conforms to the PSAB Report Template
- The IMR takes into account the specific Terms of Reference for this review
- The IMR is:
    - Comprehensive,
    - Well-structured,
    - Includes good analysis of the information
    - Provides explanations for any practice which may be of concern
    - Places emphasis on key findings and lessons
    - Has sound and SMART recommendations

Signed: Date:

…… ……..

Name and Position: ……
(PLEASE PRINT)

Senior Manager responsible for signing off Individual Agency Management Report

APPENDIX C- Records**/**documents reviewed**/**examined including policies and procedures

- Please list them here.

APPENDIX D - Persons seen / interviewed

Name	Dates	Interviewed by