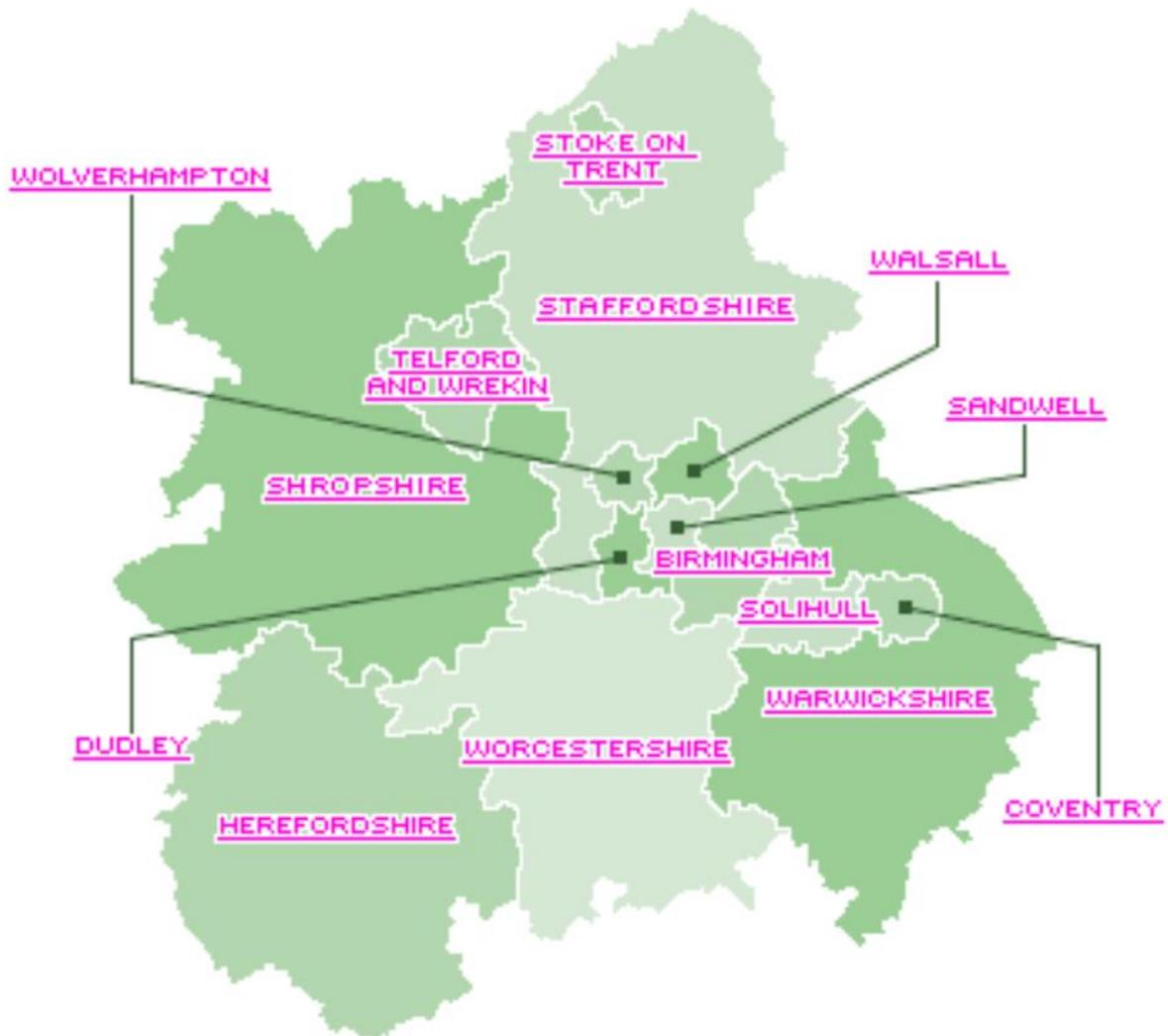


# West Midlands Regional Safeguarding Adult Review (SAR) Policy



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## 1. Introduction

The Care Act 2014 requires Safeguarding Adult Boards to arrange Safeguarding Adults Reviews, and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology (see appendix 1. for options).

This Policy is a Pan West Midlands document and should be read in accordance with:

- Local Board procedure.
- Serious Case Review Quality Markers (national equivalent for adults awaited).

## 2. SAR Criteria

*Criteria from s44 of the 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<sup>1</sup> 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).

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<sup>1</sup> 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.

### **3. Purpose**

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 in practice to prevent similar harm occurring again.

SARs should help to achieve understanding for individuals, families and friends of adults who have died or been seriously abused or neglected.

The purpose of the reviews 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.

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.

### **4. Principles**

The following principles apply to all reviews:

- The individual (where able) and their 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;
- Professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.
- 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;
- Safeguarding Adult Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed; and

- The Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practice

## 5 SAR Methodologies

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options. No one model or methodology will be applicable for all cases, the SAB will need to weigh up what type of 'review' process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again (see appendix 1. For the range of methodologies that can be considered).

The ultimate decision to arrange a SAR is the responsibility of the Chair of the SAB.

## 6 Duty of Candour

All members of a SAB are expected to have a culture of openness, transparency and candour within their day to day work and with the SAB including any SARs undertaken. In interpreting this "duty of candour", we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

**Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

**Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

**Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

**In practice** - as a member of the SAB all agencies have a responsibility to ensure it is open and transparent with the SAB when certain incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incident that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying own learning and multi-agency learning.

## **7 Cross Boundary SARs**

It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is not in the SABs area. If that is the case, a SAR should be carried out by the Board that is responsible for the location where the serious incident took place.

Early consideration should be given inviting a representative from the SAB of the funding area to participate in the SAR. The SAB representative from the funding area has the responsibility of sharing all learning and ensuring and recommendations/actions for their area are implemented within agreed timescales.

Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

## **8 SARs and Childhood Experience of Abuse**

SARs should be undertaken in accordance with the criteria identified above and focusses on a person's experience of abuse as an adult.

It is acknowledged that there will be cases where adults have moved from Children's to Adult Services and their predominant experience of abuse happened before the age of eighteen. Early consideration should be given to identifying the most appropriate route for responding to the concerns raised for example, historic child abuse may be more appropriately dealt with by the Police or reviewed by Local Childrens Safeguarding Board (LSCB).

Boards and organisations should cooperate across reviews and requests for the provision of information should be responded to as a priority.

Appendix 2 provides more information about the interface with other reviews.

## **9 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 (for example, 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, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

In setting up a SAR the SAB should also 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.

It may be helpful when running a SAR and DHR or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. Any 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 manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

## 10 Resolving disagreements

If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the Chair of the Safeguarding Adult Board. If agreement can still not be reached this should be escalated to the Local Authority's Chief Executives.

As a last resort a complaint can be made to the Local Government Ombudsman if the complainant:

- Disagrees with SAB decision to not undertake a safeguarding adult review;
- Unhappy with decision of a SAB or outcome of a safeguarding adult review;
- Makes a complaint is about the makeup of the SAR and potential conflict of interest;
- Is concerned the Chair of the SAB is also the chair of the SAR; or
- Is unhappy with the conduct of a professional on an SAB who is employed by a body that falls outside the LGO's jurisdiction.

## 11 References

Care Act 2014

Department of Health (October 2014) Care and Support Statutory Guidance – issued under the Care Act 2014.

Social Care Institute for Excellence (2015) Safeguarding Adults Reviews under the Care Act – implementation support.

ADASS Safeguarding Adults Policy Network – Guidance - June 2016

Out-of-Area Safeguarding Adults Arrangements - Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements

Coventry Safeguarding Adults Board – Safeguarding Adults Review Toolkit

Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol  
January 2016

London Joint Improvement Programme: Learning from Serious Case Reviews on a  
Pan London Basis, Sue Bestjan, March 2012

Working Together to Safeguard Children - A guide to inter-agency working to  
safeguard and promote the welfare of children March 2015

## SAR Methodologies and Checklist

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another.

### 1 Traditional Serious Case Review model

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

#### This model includes

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning
- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

#### The benefits of this model are:

- its is likely to be familiar to partners
- possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- robust process for multiple, or high profile/serious incidents.

#### The drawbacks of this model are:

- methodology stems from children's arena so process to adults is not so familiar
- resource intensive
- costly
- can sometimes be perceived as punitive and
- does not always facilitate frontline practitioner input.

### 2 Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual

circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- cost effective
- enhances partnership working and collaborative problem solving
- encompasses frontline staff involvement
- learning takes place through the process enhancing learning.

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

### 3 Individual Agency Review

This model would be relevant when a serious incident identifies just one agency involvement or one agency learning identified. – there are no implications or concerns regarding involvement of other agencies and it is appropriate that lessons are learnt regarding the conduct of an agency and in the absence of the need for a multi-agency review.

Such reviews could be requested by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking a Individual Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships.

#### Circumstances when this model might be appropriate:

- Serious Incidents
- Implications relate to an individual agency but lessons could be shared, applied and learnt across the partnership
- Where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

#### The benefits of this model are:

- Provides an opportunity for learning from a individual agency
- Enables individual agency scrutiny into a specific area
- Assists a 'Duty of Candour'

#### The drawbacks of this model are:

- Can be seen as outside the SAR purpose of multi-agency learning
- Risks individual agency opposition.

### 4 Peer Review Approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasing used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

#### There are two main models for peer review:

- peers can be identified from constitute professionals/agencies from the Safeguarding Adults Board members or
- peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- increased learning and ownership if peers are from the SAB
- objective, independent perspective
- can be part of reciprocal arrangements across/between partnerships
- cost effective

The drawbacks of this model are:

- capacity issues within partner agencies may restrict availability and responsiveness
- skill and experience issues if SARs are infrequent potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

## **5 Significant Event Analysis/Audit (SEA)**

SAE is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it.

The benefits of this model are:

- It is not a new technique – doctors have long discussed cases for educational and professional purposes.
- NHS England has published Serious Incident Framework in March 2015

The drawbacks of this model are:

- Seen as a model that relates only to Health.

## **6 Case File Audit (multi or single agency, table top of interactive)**

Case file audit can be a powerful driver in improving the quality of front line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

- As a table-top exercise (therefore no input from practitioners)
- Interactive with partners and or practitioners.
- Interactive with the adult and or their family.
- Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- Flexible – in that they can be conducted in many different ways.
- Quicker learning can be achieved.

The drawbacks of this model are:

- Learning from some models will only come from written records without relevant context.

## **7 Root Cause Analysis (RCA)**

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors - the Root Causes- of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop an open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes
- to be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence
- there is usually more than one potential root cause of a problem
- to be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS
- Focus is on the root cause and not on apportioning blame or fault
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

## **8 Thematic Reviews**

A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or investigation. Themes may also be identified by the Performance and Quality Assurance Subgroup. A thematic review considers an individual case as a starting

point, but looks at issues raised generally, rather than the details specific to the case.

- Findings are collated from involved agencies or previous reviews
- The legal framework, risk and communication are considered
- An academic literature review is undertaken
- Policy documents are reviewed
- Interviews are held with practitioners
- Multi-agency response is considered

The benefits of this model are:

- Increased opportunity for wider learning
- Cost effective
- Engagement with staff and managers at different levels within organisations

The drawbacks of this model are:

- Workloads of those involved may create capacity issues
- Resource intensive
- Unfamiliar methodology

## 9 Checklist

Whichever model or approach is used, there are a number of key considerations. This checklist has been developed to help SABs undertake successful SARs.

<p><b>Terms of Reference</b> <i>Mandatory</i></p> <p><b>Essential</b></p>	<p>Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken.</p> <p>Well formulated terms of reference are essential to ensure that the review is:</p> <ul style="list-style-type: none"> <li>• properly scoped</li> <li>• manageable</li> <li>• conducted by the appropriate people</li> <li>• within agreed timeframes.             <ul style="list-style-type: none"> <li>– To establish facts of the case</li> <li>– To analyse and evaluate the evidence</li> <li>– To risk assess</li> <li>– Make recommend</li> </ul> </li> </ul> <p>Ensure the review will answer “<b>THE WHY</b>” question.</p>
<p><b>Interface with other review processes</b> <i>Mandatory</i></p>	<p>Before starting a SAR identify if there is any links to other reviews and identify which takes priority. For example:</p> <ul style="list-style-type: none"> <li>• DHR</li> <li>• Children’s SCR</li> </ul>

<p><i>See Appendix</i></p>	<ul style="list-style-type: none"> <li>• Serious Further Offence Review (Probation)</li> <li>• Mental Health Review</li> </ul> <p>In addition - Consider previous SAR's – will a recent SAR reinforce the same learning or is new learning to be identified?</p>
<p><b>Family &amp; significant others involvement</b> <i>Mandatory</i></p>	<p>Identify the degree to which victims/families will be involved in the review and how they will be informed of this review.</p> <p>Victims/families (family members who have played a significant role in the life of the service user) should be notified that the review is taking place. Involvement can be:-</p> <ul style="list-style-type: none"> <li>• Formal notification only</li> <li>• Inviting them to share their views in writing or through a meeting.</li> </ul> <p>The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.</p> <p>Victims/families should be offered support.</p>
<p><b>Independent Advocacy</b> <i>Mandatory</i></p>	<p>The local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding adult review. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 then, unless inappropriate, the same advocate should be used.</p> <p>It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process.</p>

<p><b>Chair</b> <i>Mandatory</i></p>	<p>Each SAR will require a skilled and competent Chair of the panel considering the SAR, receiving IMRs and agreeing the report and recommendations. When identifying who to chair the panel – consider:</p> <ul style="list-style-type: none"> <li>• Are they independent of the case?</li> <li>• In single agency reviews – are they independent of the single agency that it involves?</li> <li>• Do they need to be independent of the SAB?</li> <li>• What skills, knowledge and expertise do they specifically need?</li> </ul>
<p><b>Panel</b> <i>Mandatory</i></p>	<p>Each SAR should be presented to a panel for scrutiny.</p> <p>The panel should be made up of a minimum of 3 people excluding the chair.</p> <p>They must be:</p> <ul style="list-style-type: none"> <li>• independent of the IMR authors</li> <li>• Independent of the case</li> <li>• Knowledgeable of the issues/subject area.</li> </ul>
<p><b>Practitioner involvement</b> <i>Mandatory</i></p>	<p>Practitioners will be involved in all SAR's – however the level of their involvement can be varied.</p> <p>The following should be considered:</p> <ul style="list-style-type: none"> <li>• Interviewing and taking a statement from practitioners for IMR's can result in staff having heightened anxiety.</li> <li>• Practitioners must be offered support throughout a SAR.</li> <li>• Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome.</li> </ul> <p>Multi agency learning events that involve practitioners can:</p> <ul style="list-style-type: none"> <li>• be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event.</li> <li>• Assist practitioners to contextualize what happened and achieve closure.</li> <li>• Result in quicker and more enhance learning.</li> <li>•</li> </ul>

<p><b>Experts</b> <b>Optional</b></p>	<p>Consider if an expert is required to help to fully understand the situation and IMR findings.</p> <p>If possible identify which expert will be needed or may be needed at the start of the process. However expert can be called upon at any time during the process.</p>
<p><b>Overview Report &amp; Executive Summary</b> <b>Mandatory</b></p>	<p>An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced.</p> <p>An Executive Summary may also be commissioned.</p> <p>All reviews of cases meeting the SAR criteria should result in a report which is published and readily available on the SABs website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to demonstrate openness, transparency and candour and to support national sharing of lessons. From the start of the SAR the fact that the report will be published should be taken into consideration. SAR reports should be written in such a way that publication will be likely to harm the welfare of any adult with care and support needs or children involved in the case. Exclusion to this rule would be single agency reviews if individuals can be identified.</p> <p>Final SAR reports should:</p> <ul style="list-style-type: none"> <li>• provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;</li> <li>• be written in plain English and in a way that can be easily understood by professionals and the public alike; and</li> <li>• be suitable for publication without needing to be amended or redacted.</li> <li>•</li> </ul>

**Independent Author**  
*Optional*

In the following situations it may be beneficial to consider an author who is NOT the chair:

- Very difficult and complex cases to enable the chair to concentrate in chairing
- Due to the specialist nature of the subject.
- To enable the chair to be from the SAB and be the chair as part of his day to day work.

An independent author must be:

- Independent of the case
- Independent of the organisations involved
- Appropriately skilled and competent.

They may also be independent of the SAB.

**Timescales**

Where ever possible SARs should be completed within 6-months.

## Interface with other reviews

Review	Precedence
<p><b>Domestic Homicide Reviews (DHR)</b></p> <p>Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.</p> <p>For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.</p>	<p>When the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that:</p> <p>the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by -</p> <p>(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or</p> <p>(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.</p>
<p><b>Children’s Serious Case Review (SCR)</b></p> <p>Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances.</p> <p>For further guidance see – HM Government - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children 2013</p>	<p>When abuse or neglect is known - or suspected - and either:</p> <ul style="list-style-type: none"> <li>• a child dies</li> <li>• a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child</li> </ul>
<p><b>Mental Health Reviews/Suicide Review</b></p>	<p>When a person who is in contact with mental health commits suicide, NHS boards undertake a suicide review to analyse what happened and recognise where anything can be done to make things safer for other people at risk.</p>

## **Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review**

**Criminal Justice and Court Services Act 2000 - strengthened by the provisions of the Criminal Justice Act 2003 (s325-327).**

**When the main purpose is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.**

## **Serious Further Offending Notification and Review Procedures**

**Offender Rehabilitation Act 2014**

**Reviews will be required in any of the following cases:-**

- **any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the NPS or a CRC; or whilst subject to ROTL. In addition, this will also apply during the 28 day period following conclusion of the management of the case; or**
- **any eligible offender who has been charged with another offence on the SFO qualifying list committed during a period of management by the NPS or a CRC and is or has been assessed as high/very high risk of serious harm during the current sentence (NPS only) or has not received a formal assessment of risk during the current period of management; or**
- **any eligible offender who has been charged with an offence, whether on the SFO list or another offence, committed during a period of community management by the NPS or a CRC, and the provider of probation services or NOMS has identified there are public interest reasons for a review. This may be due to significant media coverage Ministerial interest or where reputational risks to the organisation may arise; or**
- **if the offender has died and not been charged with an eligible offence but where the police state he/she was the main suspect in relation to the**

commission of a SFO.

## **Learning Disabilities Mortality Review (LeDeR)**

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.

All deaths of people with learning disabilities aged 4 years and over will be reviewed, regardless of whether the death was expected or not, the cause of death or the place of death.

The LeDeR programme is using the definition of learning disabilities provided in the 2001 White Paper "Valuing People". For more information see the briefing paper here: [Briefing paper 1 - What do we mean by learning disabilities \(PDF, 607kB\)](#)