



Cumbria Safeguarding Adults Board

Serious Case Review Procedure

As with all procedures they are all subject to review.
Please check date and Version number.



Contents

Section		Page
	Contents	2
	Information page	3
1	Introduction	4
2	Definition	5
3	When should a Serious Case Review be undertaken?	5
4	Who can refer a case to the Cumbria Safeguarding Adults Board for consideration?	5
5	Process and procedure to be followed when referring a case for consideration	6
6	Request from the Chair of the Cumbria Safeguarding Adults Board to the Serious Case Review Panel	6
7	The Review Panel's recommendation about whether a Serious Case Review should be conducted	7
8	The Serious Case Review Panel's considerations	7
9	Securing case files and records	8
10	Individual management reviews	9
11	Format for individual management reviews	9
12	Disciplinary process	10
13	The Cumbria Safeguarding Adults Board overview report	10
14	The Cumbria Safeguarding Adults Board receiving the overview report	11
15	The Executive Summary	11
16	The Action Plan	12
Appendix A	Flow Chart	13
Appendix B	SCRP – Terms of Reference	17
Appendix C	Individual Management Review - guidance	18

Information Page

Date procedure agreed by Cumbria Safeguarding Adults Board	17/06/09
Date effective from	17/06/09
Date of review(s)	17/12/09
Circulation to	Managers in all partner agencies represented on Cumbria Safeguarding Adults Board
Copies of document available from	www.cumbria.gov.uk/adultsocialcare/safeguarding Or Safeguarding Adults Coordinator Cumbria Adult & Cultural Services County Offices Kendal LA94RQ
Related document(s)	Cumbria Safeguarding Adults Multi Agency Policy & Procedures –2008 Cumbria Safeguarding Adults Practitioners Guide “No Secrets” Department of Health and Home Office - 2000

1. Introduction

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

'No Secrets' suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees. In Cumbria, this forum is called the Cumbria Safeguarding Adults Board (CSAB).

The document 'Safeguarding Adults' published by the Association of Directors for Social Services (ADSS) October 2005 provides a National Framework of Standards for good practice and outcomes in adult protection work. One of the standards in this document states that, as good practice Safeguarding Adults Boards/Adult Protection Committees should have in place a Serious Case Review protocol.

There is no statutory requirement for agencies to cooperate with such reviews. However, voluntary involvement does lead to good practice development.

'Working Together to Safeguard Children' (H M Government 2006), in Section 3.39 (e), describes the Local Safeguarding Children Board (LSCB) function, in relation to Serious Case Reviews, as follows:

'Undertaking reviews of cases where abuse or neglect of a child is known or suspected and either a child has died, or a child has been seriously harmed and there is a 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.'

The earlier version of 'Working Together to Safeguard Children' (1999) states that an Area Child Protection Committee (ACPC) (the precursor to the Local Safeguarding Children Board) *'should always undertake a serious case review when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.'* It adds that an ACPC should always consider whether to commission a serious case review *'where a child has sustained a potentially life threatening injury through abuse or neglect, ...or sustained serious and permanent impairment of health and development and the case gives rise to concerns about the way in which local professionals and services work together to safeguard children'*.

The Cumbria Safeguarding Adults Board has used the valuable experience of safeguarding children/child protection services, translating the 'Working Together..' arrangements to inform this Serious Case Review procedure, which aims to support positive developments in adults' services.

2. Definition

There are various definitions in existence, of what might constitute a serious case review. Broadly, it is a retrospective, inter-agency review of a case, to consider whether there are lessons to be learnt about the ways in which agencies worked together to safeguard vulnerable adults (or children).

3. When should a Serious Case Review be undertaken?

The Cumbria Safeguarding Adults Board (CSAB) should conduct a serious case review in the following circumstances:

- 3.1** When a vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the vulnerable adult's death.
- 3.2** Consideration should always be given to whether to undertake a serious case review:
 - a) When a vulnerable adult has sustained a potentially life-threatening injury or permanent impairment of health or has been the victim of very serious abuse e.g. systematic sexual abuse.

And

- b) The case gives rise to concerns about the way in which professionals and services work together.

Where a case is referred to the CSAB for consideration for Serious Case Review and is found not to meet the necessary criteria (3.1, 3.2 above or 4.2 below), but the case has raised concerns about the way in which professionals or services worked together, the CSAB should make recommendation(s) for its consideration through another, appropriate reviewing mechanism. This may include a recommendation that an agency undertake an internal review and feed any learning points back to CSAB.

4. Who can refer a case to the Cumbria Safeguarding Adults Board for consideration?

Any agency or professional can refer a case to the CSAB Chair if it is believed that:

- 4.1** The above (3.1 and 3.2) circumstances are met

or

- 4.2** It is believed that there are important lessons for interagency working, following the death of a vulnerable adult.

5. Process and procedure to be followed when referring a case for consideration

A staff member who believes a serious case review is warranted should discuss their concern the case in question, with their Cumbria Safeguarding Adults Board (CSAB) representative. The agency CSAB representative should arrange for a request for a Serious Case Review to be submitted to the CSAB Chair.

The Chair of the CSAB will decide whether the case warrants initial discussion at the Serious Case Review Panel (SCRCP - a sub-committee of the CSAB).

The Review Panel is made up of a representative of each of the following agencies:

- Police
- NHS
- Adult & Cultural Services (Adult Social Care)

Other members can be co-opted onto the Panel by the Chair of the SCRCP sub group as required by the circumstances of individual cases.

The Chair of the CSAB, along with other members, will decide who will chair the Serious Case Review Panel.

The Review Panel will consider, in the light of information known by agencies, whether the criteria are met as set out in Sections 3 and 4 above.

In order for the Review Panel to make informed decisions about whether the criteria are met, agencies' case files need to be secured, immediately the Chair of the CSAB has requested the Panel to meet. The SCR Chair will inform agencies when this is necessary and set a date for the first meeting of the Panel where all invited agencies must prioritise attendance (or arrange for suitably placed deputies to attend).

6. Request from the Chair of the Cumbria Safeguarding Adults Board to the Serious Case Review Panel

- 6.1** The Serious Case Review Panel should meet within 7 days of request from the Chair of the Cumbria Safeguarding Adults Board.

6.2 Within 4 weeks of the original request from the Chair of the CSAB, the Serious Case Review Panel should:

- a) Make a recommendation to the CSAB Chair on what action is necessary in each case

and

- b) If a Serious Case Review is to take place, draw up a Terms of Reference.

Where any other review is taking place in parallel with the Serious Case Review, regarding the same case, the above process (6.2) will serve the purpose of bringing these together.

7. The Review Panel's recommendation about whether a Serious Case Review should be conducted

The Review Panel's decision will be forwarded to the Chair of the CSAB, who has ultimate responsibility for deciding whether or not to conduct a Case Review.

The CSAB Chair should:

- a) Inform the Commission for Social Care Inspection of any case that becomes the subject of a Serious Case Review
- b) Inform the CSAB of the decision, brief circumstances and scope of review.

8. The Review Panel's considerations

8.1 The Review Panel will need to consider the scope of the Review, including:

- a) Whether in some cases there should be an individual Management Review or smaller scale audit of a case that gives rise to concern but does not meet the criteria for a full Serious Case Review
- b) Brief circumstances and the scope of the Review.

8.2 In all such cases, CSAB arrangements will need to be followed in terms of:

- a) Brief circumstances and the scope of the Review
- b) Information sharing
- c) Formal feedback by way of written report to the CSAB

8.3 Relevant issues for consideration are:

- a) What period of time should the Review cover, i.e. how far back should the enquiries go?
- b) What family history/background information do agencies already have and what needs to be captured to help a better understanding of the circumstances of the event(s)?
- c) Are there any other professionals or individuals who have relevant information and who can help contribute to the Review? If so they should be asked to submit a written report to the Chair of the Serious Case Review Panel.
- d) What appear to be the relevant issues involved in the case?
- e) If there is more than one Safeguarding Adults partnership involved, the respective Chairs will need to agree roles and responsibilities and designate relevant staff to become involved.
- f) How should the Review take account of any Coroner's Inquiry and/or any criminal investigations? 'Working Together to Safeguard Children' Guidance states that delay in conducting the Review should not automatically follow, but that agreement should be reached between the Chair of the Cumbria Safeguarding Adults Board (CSAB) and the Crown Prosecution Service whether a delay is absolutely necessary, taking account of the view of the Police. Additionally, the view of the Coroner's Office should be taken into account when initiating a Review and it might be that in some circumstances it is not possible to complete or publish a Review until after this has been concluded.
- g) How should Media and public interest be handled before, during and after the Review? No individual agency member should speak to the press directly. Media and press interest should be managed through the CSAB Chair, who will agree and co-ordinate press statements through the Local Authority's Public Relations Department.
- h) Is there need for legal advice to the Serious Case Review Panel and, if so, who is to be approached to advise on this aspect of the task?
- i) Should family members be asked to contribute to the Review process? If this is felt to be necessary and there are parallel criminal proceedings then the Police must agree on an appropriate course of action regarding interviews, etc.
- j) Finally, who is going to conduct the Case Review and prepare the composite report for the CSAB? Independent Consultants may be useful in this area of work. The Chair of the Review Panel, in consultation with

the CSAB Chair, will agree the use of Independent Consultants once a decision has been reached on conducting a Review.

9. Securing case files and records

As soon as the CSAB Chair has requested the Serious Case Review Panel to meet to consider whether the criteria has been met for a Serious Case Review, then each key agency must secure their agency files and begin work to draw up a chronology of involvement with the vulnerable adult and family. This is necessary to secure against loss or interference in case records or files.

10. Individual management reviews

Once each key agency that had involvement with the vulnerable adult and family has been identified, then agreement should be reached about who should bring the Management Review for their respective agency. Once there has been a decision to conduct a Serious Case Review, this should begin within 6 weeks of the decision.

The aim of the Management Review is to look openly and critically at individual and organisational practice, policy and procedure to see whether the case indicates that changes should or could be made and, if so, to identify how these changes can be achieved.

Section 11 sets out the standard format for agencies conducting individual Managements Reviews and assists the CSAB to receive reports in a consistent way.

The nominated agency management representative should undertake a rapid appraisal of the case, to determine whether there is a need for immediate changes to practice and procedure.

See Appendix C for an IMR format.

11. Format for individual management reviews

11.1 Construct a chronology of involvement by the agency or professional in contact with the vulnerable adult and over the period of time set out in the Review's Terms of Reference.

11.2 Summarise the decision reached, the services offered and provided to the vulnerable adult, and any other action taken.

11.3 Consider:

- a) What policy and procedure was in place to guide the practitioners to safeguard the vulnerable adult?
- b) Was action taken to deal with concerns about their welfare?
- c) What assessments took place, if any, and did they take account of guidance frameworks in common use?
- d) Were relevant enquiries made to assist an assessment?
- e) Were appropriate services offered?
- f) Were the vulnerable adult's wishes and feelings taken account of, in the process of assessment and service provision?
- g) Was practice appropriate to the identity of the vulnerable adult in terms of, for example, race, culture, language, religion, age, gender and orientation?
- h) Were senior managers involved in appropriate decisions?
- i) Was the work consistent with "Safeguarding Adults in Cumbria – Multi Agency Policy and Procedures"?
- j) Was the work consistent with other professional standards?
- k) Was there appropriate consultation with other agencies?

11.4 Lessons learned

- a) What did the agency learn from this case on safeguarding and promoting a vulnerable adult's welfare?
- b) Was there good practice to highlight, or practice that could have been improved?
- c) Are there any training implications and/or supervision issues to be highlighted for the agency?
- d) Were there resource implications identified?
- e) Were there partnership issues identified?

11.5 Recommendations for Action and Action Planning

- a) What action should be taken by the agency, by whom, when and how will they be followed up?
- b) What outcomes should these actions bring about?
- c) How will the agency achieve improvement in action, policy or procedure?

12. Disciplinary process

Serious Case Reviews are not part of any disciplinary process but information that emerges in the course of a Review may indicate that disciplinary action should be taken under established procedures in the agency concerned.

Alternatively, disciplinary action may be conducted concurrently and in some situations disciplinary action may need to be taken urgently to safeguard other vulnerable adults. This will be a matter for the individual agency concerned. Judgements and decisions on whether an individual or a number of individuals pose a risk to vulnerable adults can be considered through the inter-agency adult protection process.

13. The Cumbria Safeguarding Adults Board Overview Report

13.1 Once each agency has completed its own agency review, an Overview Report will be completed, which brings together all agencies' individual Reviews and will include a list of recommendations for the CSAB to consider.

13.2 The Overview Report should be completed within four months of the Serious Case Review commencing and make a recommendations to the CSAB Chair.

13.3 Any digression from this should be agreed with the Chair of the CSAB.

13.4 The Overview Report Format:

- a) Introduction - a summary of the circumstances of the case being reviewed.
- b) Terms of Reference
- c) List of contributors to the Review
- d) Sources of information used in the Review
- e) The facts, including family tree
- f) Inter-agency chronology of events
- g) Overview of information known to the agencies
- h) Analysis
- i) Findings and conclusions
- j) Recommendations

14. Cumbria Safeguarding Adults Board (CSAB) receiving the overview report

On receiving an Overview Report the CSAB will:

- a) Check contents with contributors
- b) Draw up and agree a management action plan

- c) Clarify to whom the report, or any part of it, should be made available
- d) Disseminate report or key findings to interested parties as agreed
- e) Make arrangements to feedback to staff, family members and the media if appropriate
- f) Provide a copy of the Overview Report, Executive Summary Action Plan and individual management reports to the Commission for Social Care Inspection (CSCI)

15. The Executive Summary

15.1 In all cases the report author should prepare an Executive Summary Report, which will be made public and which will include, as a minimum:

- a) Information about the Review process
- b) Key issues arising from the case
- c) Recommendations

15.2 The Summary will be agreed by Serious Case Review Panel and presented to the Chair of the CSAB who will take into consideration any related criminal proceedings findings.

15.3 Family members will usually be given copies of the Executive Summary, when the Chair of the CSAB has agreed a release date.

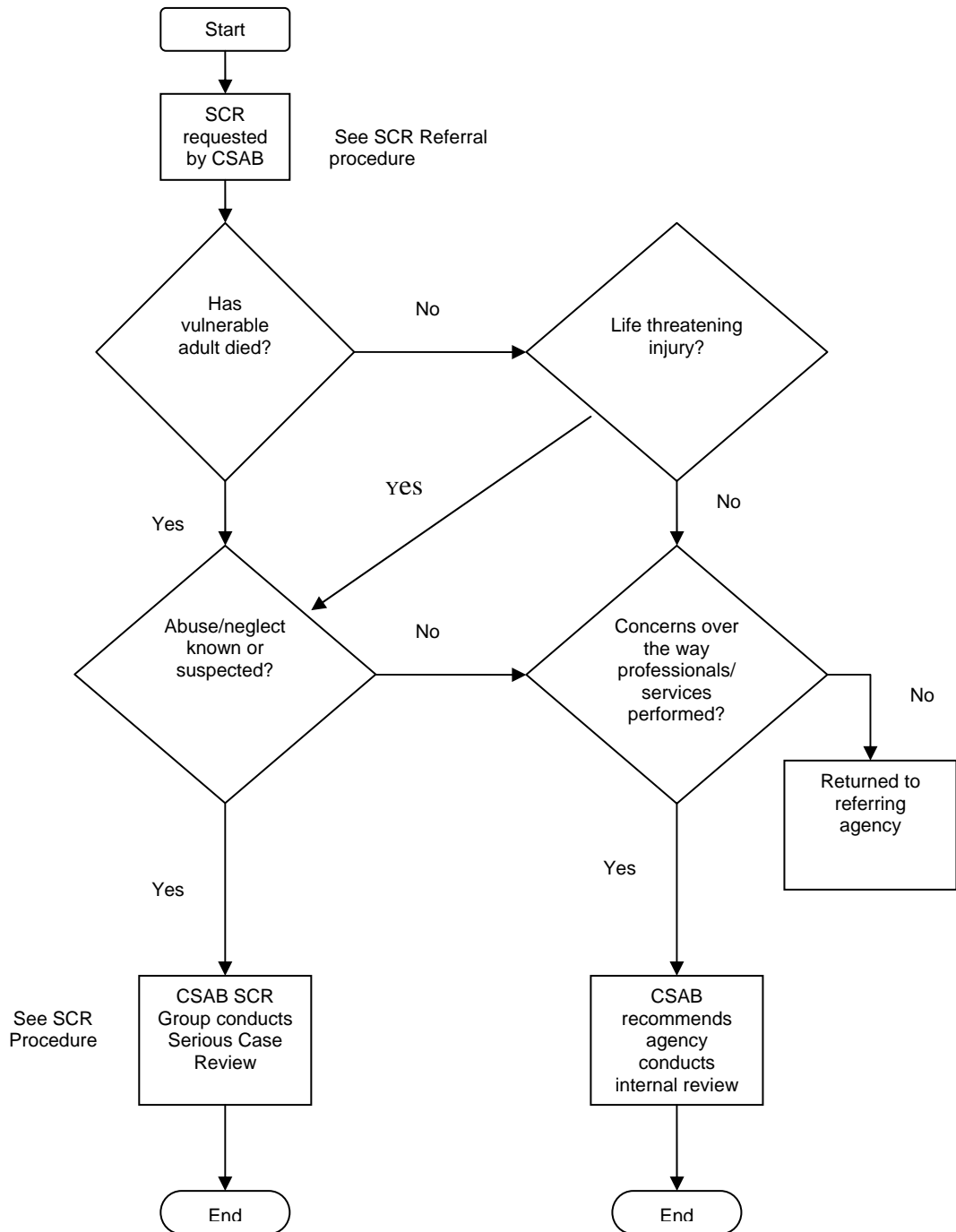
15.4 Media interest will be co-ordinated through the CSAB Chair and press statements will be co-ordinated through the Local Authority's Public Relations Department, which should have the agreement of the Chief Executive.

16. The Action Plan

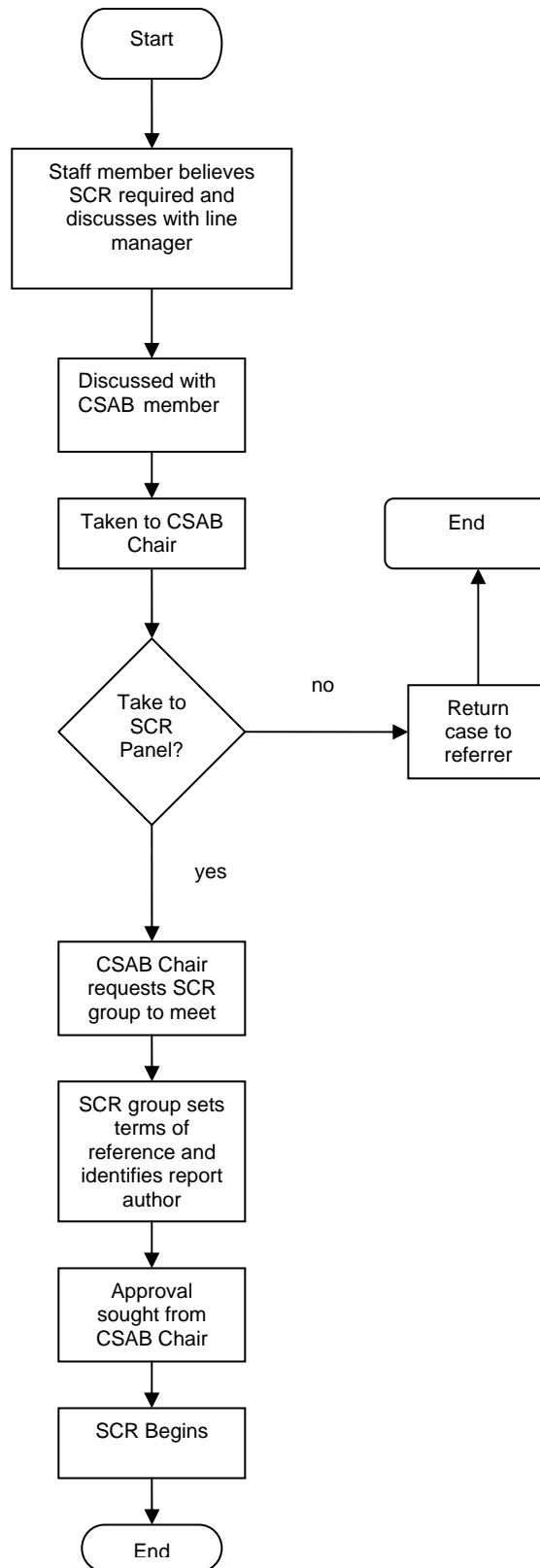
At the conclusion of each Serious Case Review the Chair of the CSAB will write to the agencies identified in recommendations to make them aware of the areas for improvement and request that they formulate an action plan to deal with these. The agencies should be given a timescale of four weeks to respond to CSAB with an action plan including the timescale proposed for completion.

Agencies subject to action points must provide evidence to CSAB that the Action Plan in respect of their agency is being or has been implemented.

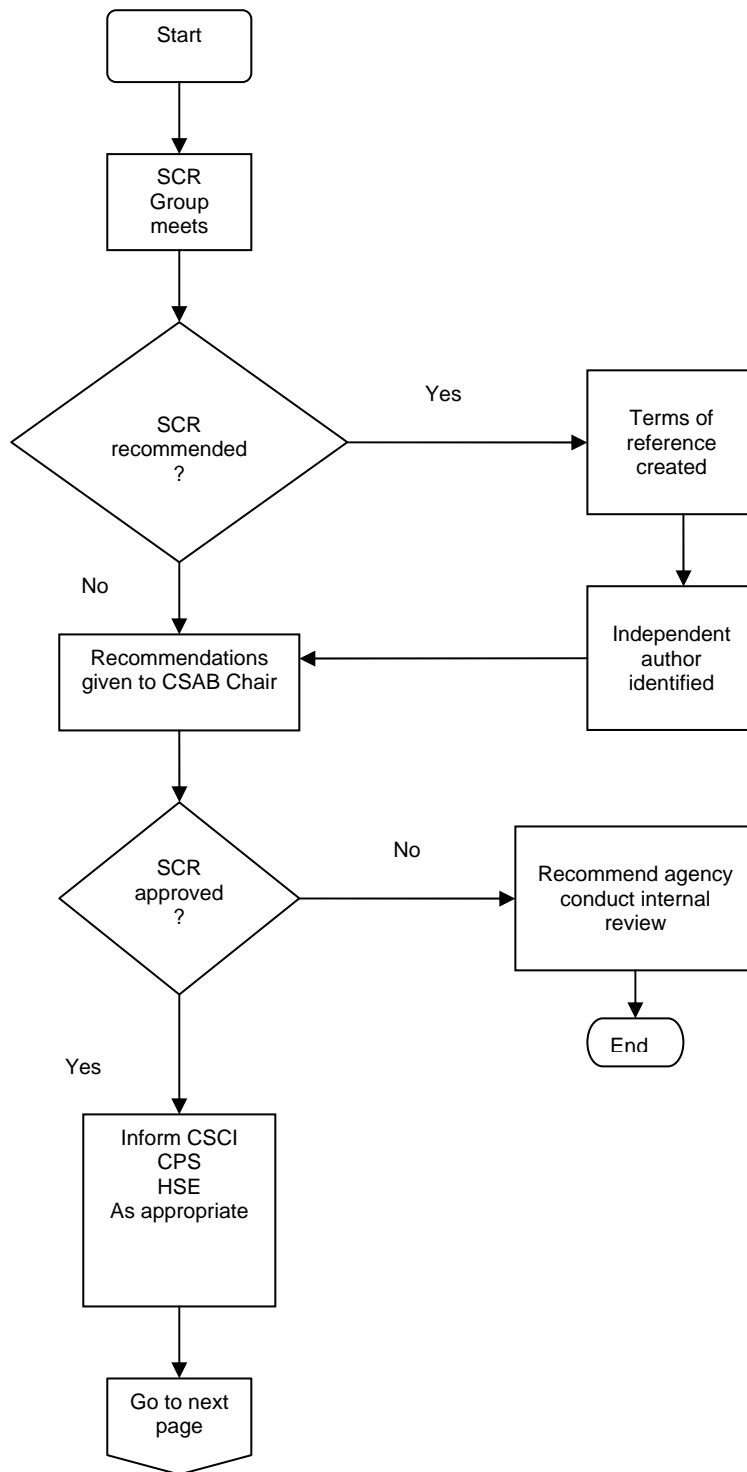
Appendix A (i) – Flow Chart – Overview

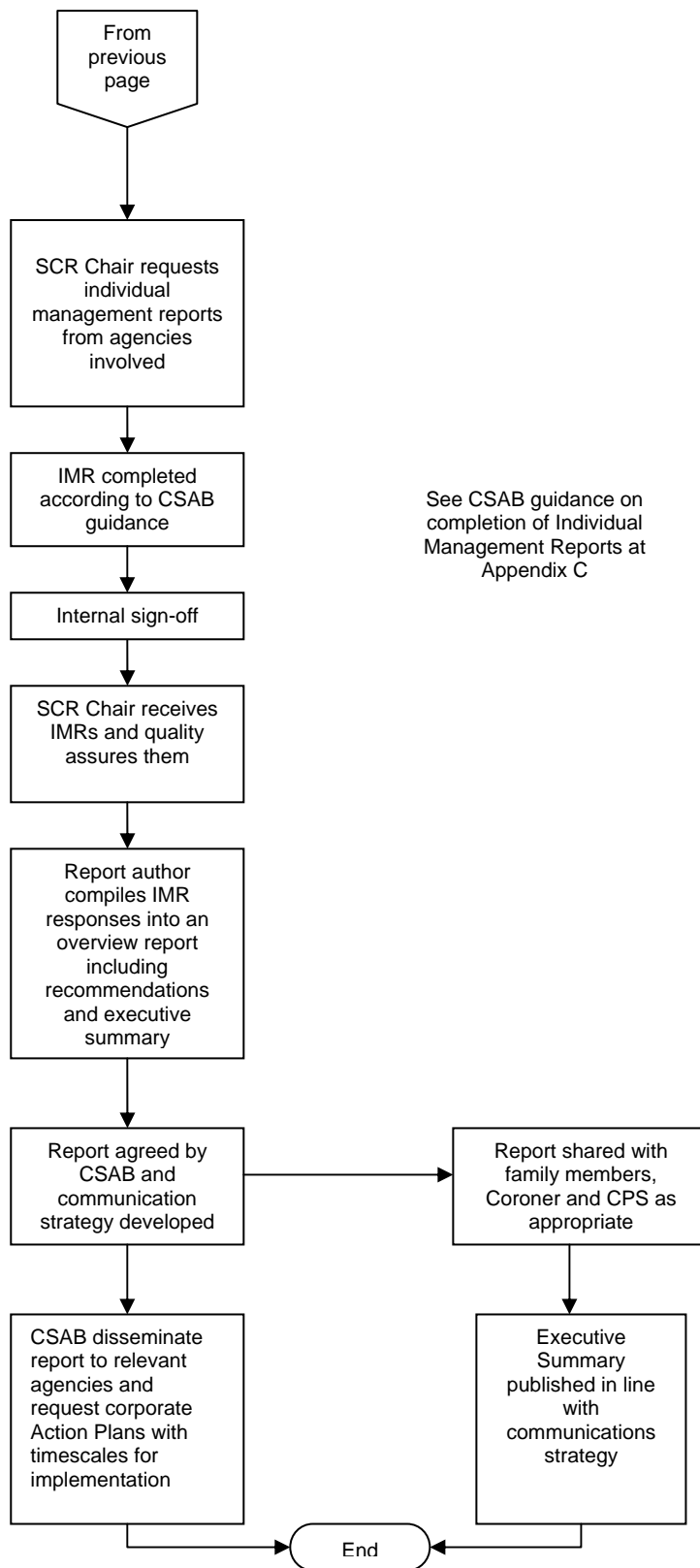


Appendix A (ii) – Flow Chart – Referral Process



Appendix A (iii) – Flow Chart – SCR Procedure







Appendix B

Serious Case Review Panel

Terms of Reference

1. When an adult dies (including death by suicide), and abuse or neglect are known or suspected to be a factor in the death, to advise the Safeguarding Adults Partnership chair;
 - That a serious case review should be conducted
 - On the terms of reference of the review
 - On the proposed membership of the Review Panel
 - Whether an independent chair can be found from within the SCR Sub-Group or whether an external consultant/chair is required to act as Chair and, if so, to suggest the area of expertise required.

2. To consider whether a Serious Case Review should be conducted where an adult;
 - sustains potentially life-threatening injury or permanent impairment of health through abuse or neglect or has been the victim of very serious abuse e.g. systematic sexual abuse

and

 - where the case gives rise to concerns about inter-agency working to protect vulnerable adults from harm

3. To ensure that any lessons arising from a review are understood and acted upon.



Cumbria Safeguarding Adults Board

Appendix C

Individual Management Review Guidance



Please Note: When completing the review on the attached template, the notes in [blue](#) are there to provide support and guidance to authors. These must be deleted before your management report is submitted to Cumbria Safeguarding Adults Board (CSAB).

When a Serious Case Review is to be held, and an agency will be submitting an Individual Management Review Report, these will only be accepted using the following format and templates.

Agencies will receive a letter giving two dates for submission;

- **A date for submission of a completed comprehensive family composition and chronology**
- **A subsequent date for submission of the remainder of the review report, including analysis and recommendations for action.**

The letter will provide contact details for the return of this information.

Where the SCR Panel Chair and its members consider that an Individual Management Review Report is not of sufficient quality to aid the analysis and learning required for a SCR, these will be returned for revision to the agency involved. This will be referred to in the Overview Report.

STRICTLY CONFIDENTIAL

INDIVIDUAL MANAGEMENT REVIEW REPORT

Subject:

DOB:

Author: (Please insert Name and Designation of report author here. You also need to use this section to state what your role is, how this equips you to undertake this review, and clarify that you do not have any operational involvement in the case)

Countersigned: (Please insert name and designation of person signing off the report on behalf of the agency - usually the Lead Director for Safeguarding within the organisation)

Date: (please insert date the report was submitted to CSAB Administrator)

TABLE OF CONTENTS

- SECTION 1 Introduction**
- SECTION 2 Family Composition**
- SECTION 3 Comprehensive chronology template**
- SECTION 4 Analysis**
- SECTION 5 What do we learn from this case?**
- SECTION 6 Recommendations for Action
Action Plan template**

SECTION 1 INTRODUCTION

This is an example introduction to the report. You do not have to use these phrases exactly, but this example introduction sets out the rationale for an Individual management review report.

This individual management review report of **(insert NAME OF ORGANISATION here)** is produced in accordance with Cumbria Safeguarding Adults Board procedure for conducting a Serious Case Review. It will form part of a multi-agency Serious Case Review overview report.

This report has been prepared following a review of the care/services provided to the vulnerable adult. Its purpose is to look openly and critically at individual and organisational practice to see whether the case indicates changes could and should be made, and if so, to identify how those changes will be brought about.

We have included what we consider to be relevant to the terms of reference for this Serious Case Review. The following sources of information regarding **(insert Name of Subject(s) here)** have been used to inform the report:

Please list those that your agency has used to compile your report here Make sure you delete any that do not apply to your agency. The following are examples of sources of information:

- (i) Chronology compiled from Adult Health/Patient Records (e.g. Care Home records)
 - (ii) Consultation notes made by named Adult Protection professionals
 - (iii) General Practitioner notes
 - (iv) Social Worker Records
 - (vii) Interviews with: - (Job title, not the name of the person)
- Etc.....

The current draft terms of reference for the SCR are as follows. These have been taken into account in the completion of the management review report. However, it is noted that these are currently draft only, and will be finalised at the initial meeting of the SCR Panel.

Draft terms of reference for the SCR will be inserted here when this template is sent out to you.

SECTION 2 FAMILY COMPOSITION

The CSAB Administrator will produce an outline family tree using the information you provide in this section. This will be confirmed and agreed by the SCR Panel and included in the Overview Report.

The focus of the report must be the vulnerable adult unless your agency has clear reasons for focussing on another person e.g. the perpetrator of an attack, or a relative.

SUBJECT

Name:
D.O.B:
D.O.D (if applicable):
Address:
Ethnicity:

FAMILY COMPOSITION

Mother:
Date Of Birth:
Address:
Ethnicity:

Father:
Date Of Birth:
Address:
Ethnicity:

Partner:
Date of Birth:
Address:
Ethnicity:

Child:
Address:
Date of Birth:
Ethnicity:

Other addresses on file:

Other household members/significant others (including grandchildren etc):

Name:
Date of Birth:
Relationship to subject

Name:
Date of Birth:
Relationship to subject

Please add additional people to this list as needed

SECTION 3 COMPREHENSIVE CHRONOLOGY

Please note: You will be required to submit a completed chronology template BEFORE the other sections of the report.

Construct a comprehensive chronology of involvement by the agency and/or professional(s) in contact with the vulnerable adult and family over the period of time set out in the review's terms of reference using the key below. Briefly summarise decisions reached, the services offered and/or provided to the vulnerable adult and family and other action taken.

Date: Use dd/mm/yy format.

Time: Use 24hr clock

Source of information: State whether information from interview with staff, case notes, supervision notes etc

Subject of recording: State who the entry relates to ie subject, partner, child, sibling etc. Use initials for the subject, family members etc

Event description: Briefly summarise what action was taken by whom, and what the outcomes was. NB DO NOT refer to workers by name. For clarity use SW1, SW2 for Social Workers involved or HV1, HV2 for Health Visitors etc. Where there is no contact by your agency for a significant amount of time during the period of the review, this should be explained in the chronology

Expected practice/standards: State whether there were existing procedures or standards relating to actions/interventions taken and whether these were followed. Use this section to highlight good practice, and where there is an absence of procedures or established practice.

Relevance to terms of reference: Identify whether entry is relevant to the terms of reference for the SCR, make note of particular terms of reference the entry relates to, making comments if appropriate. This will inform the subsequent sections of your report and aid discussion at the SCR Panel

Date	Time	Source of information	Subject of recording	Event description, action and outcome	Expected practice/standards	Relevance to terms of reference

SECTION 4: ANALYSIS

The author must review the information in the comprehensive chronology and produce a report. All abbreviations and acronyms should be fully explained.

The report must consider how the services offered took account of the individual needs of the vulnerable adult and family, and were sensitive to their racial, cultural, linguistic and religious identity. Does your agency collect this information? Does your agency use this information in assessments? Have you any evidence that these have been taken account of in the delivery of a service to the vulnerable adult and their family?

Practice at individual and organisational levels must be openly and critically analysed against national and local statutory requirements, professional standards and current procedural guidance. Your analysis should reflect willingness by your agency to challenge practice and address wider agency responsibility.

Good practice should be highlighted and areas for change in practice must be clearly identified. Where practice has changed from that detailed in the chronology ie new service or revised procedures, this should be explained in the management report.

Analysis must always relate to the **terms of reference and the time period** at the beginning of the document. Using these as headings may be a good way to construct your report.

Additional considerations to support analysis

Consider the events that occurred, the decisions made, actions taken and actions not taken. Where judgments were made or actions taken that indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider specifically: -

- When and in what way were the vulnerable adult's wishes and feelings heard and addressed? Was this information recorded? How was this responded to by your agency? Did your agency listen to the vulnerable adult? This is particularly important to include in your review report
- Were practitioners sensitive to the needs of the vulnerable adults in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about a vulnerable adult?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of vulnerable adults and acting on concerns about their welfare? If not, this needs to be addressed in your report. Were these adhered to? If not, why not?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the vulnerable adult and family?

Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? If not, why not?
- Were the assessments/actions completed within timescales?
- Were appropriate services offered/provided or relevant enquiries made in the light of assessments?
- Where no assessments were made, or actions taken the report needs to provide a rationale as to why this happened
- Were senior managers or other organisations and professionals involved at points where they should have been?

SECTION 5: WHAT DO WE LEARN FROM THIS CASE?

As part of critical analysis section, the author will identify specific lessons which his/her agency can learn from the case. These can include areas of good practice identified, as well as ways in which practice can be improved.

For example; have lessons from this case been identified for the way in which the organisation works to safeguard and promote the welfare of vulnerable adults? 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 multi-agency), management and supervision, working in partnership with other organisations, resources?

This section will inform the subsequent section on recommendations for action.

SECTION 6: RECOMMENDATIONS FOR ACTION

Recommendations for Action using the action plan template

Individual agency recommendations for action contained in this report will be considered by the SCR Panel for inclusion in the Overview Report. The SCR Panel may also recommend further actions for your agency to be included in the Overview Report. Any individual agency recommendations not included in the Overview Report are expected to be acted on within individual agency governance arrangements.

Recommendations for action must flow from the previous 'What do we learn from this case?' section. Recommendations must be included in the Action plan template and the template fully completed in order to be clear about;

What action should be taken by whom and by when?

What outcomes should these actions bring about and how will the organisation evaluate whether they have been achieved?

Case- SCR – Agency Action Plan

Lead Person
Name
Position
Phone
Email
Address

Named Person (Please specify only if different from the Lead Person)

No	Recommendation	Key Actions	Evidence	Key Outcome	Date
1.		1.1			
2.		2.1			
3.		3.1			
4.		4.1			

SCR Single-agency Action Plan Guidance notes

Action Plan	It needs to be SMART - S pecific, M easurable, A chievable, R ealistic and have T imescale - and outcome focused.
Recommendation	As they appear on the SCR Overview Report.
Key Actions	<p>Please indicate the action or serious of actions you will be taking to achieve the outcomes. Actions need to be clear, rigorous and fit for purpose.</p> <p>For example: deliver training, develop new policy, introduce new standards, review working practices, etc.</p>
Evidence	<p>Please specify which type of evidence you will provide to the Board that shows that the actions are being undertaken.</p> <p>For example: correspondence, minutes of meetings, new policy, training delivery material, etc.</p>
Key Outcomes	<p>Please indicate any expected and intended outcomes for service users and/or service delivery that will result from the 'Key Actions' taken.</p> <p>For example: increased number of multi-agency referrals and staff awareness of procedures, quicker access to services, attendance patters improved for identified children, reduction of young offenders, etc.</p>
Date	The date by which actions will be completed.
Note	The CSAB is very keen to develop a proactive, appropriate and effective means to grasp experiences and lessons learned from SCRs in order to achieve improved working practice and positive outcomes for children and young people in Cumbria. Please also note that if you have any other comments or feedback regarding your agency's implementation of the SCR recommendations or this Monitoring Process, we would be very happy to receive them.

For any further guidance on the above, please contact Cumbria Safeguarding Adults Board at the following addresses:

Name Irene Cooper
Position Safeguarding Adults Coordinator
Phone 01539 713384
Email irene.cooper@cumbriacc.gov.uk
Address Cumbria Adult & Cultural Services
County Offices
Kendal
LA94RQ

Kirsty Allard
Cumbria Safeguarding Adults Board
Secretary
01539 773651
kirsty.allard@cumbriacc.gov.uk