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| --- | --- | --- |
| **NAME:** | **YES** | **NO** |
| Evidence of a risk of significant harm to an adult that was not recognised or shared by professionals or agencies |  |  |
| Is there reasonable cause for concern about how the DSSP or a member of it or any other person involved in the adult’s care worked together to effectively protect the adult? |  |  |
| Are there clear identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults are safeguarded in the future? |  |  |
| Care Act guidance outlines that in the context of SARs (Safeguarding Adult Reviews) something can be considered as ‘serious abuse or neglect’ were, for example   * the individual would have been likely to have died but for an intervention * the individual has suffered permanent harm * the individual has reduced capacity or quality of life (whether because of physical or psychological effects) * the individual has suffered serious sexual abuse. * financial abuse where the outcome may have a long- term detrimental effect on a person’s well-being and is of a nature where there are serious negative outcomes for the individuals concerned * serious or permanent impairment of development |  |  |
| Do the case details give reason for serious concern about the way in which professionals and services worked together to safeguard the adult? |  |  |
| Is there clear evidence of a risk of significant harm to an adult that was not recognised or shared by professionals or agencies? |  |  |
| Are there serious concerns about how agencies have worked together to prevent, identify, minimise, or address a risk of significant harm and may place other adults at risk of significant harm? |  |  |
| Are there actions or omissions in a number of agencies involved in the provision of care, support or safeguarding of an adult that may have caused or be implicated in their harm? |  |  |
| Does one or more professional, agency, family member, carer or advocate consider that their concerns were not taken seriously or acted upon appropriately? |  |  |
| Does the case indicate that there may be operational failings in one or more aspects of the use of the DSSP Policies and Procedures? |  |  |
| Does the case involve serious or systematic organizational abuse from which learning could be transferred to other organisations to prevent such abuse or neglect in the future? |  |  |
| Was the adult subject to unauthorised Deprivation of Liberty? |  |  |
| Was there evidence of discrimination? |  |  |
| Is there adverse media interest or serious public concern? |  |  |
| Do the issues link to the strategic priorities of the DSPP? |  |  |
| Would a SAR (Safeguarding Adult Review) enable the DSSP to tackle practice issues before harm arises? |  |  |