

***M*ulti Agency *R*isk *M*anagement (MRM)**

**Protocol –**

***Including the***

***Multi-Disciplinary Team Protocol***

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**Multi-disciplinary Team (MDT) Protocol**

**Introduction**

Recent findings from local Safeguarding Adult Reviews, such as [Adult E (November 2021) and Adult G (April 2022)](https://www.rochdalesafeguarding.com/p/about-us/safeguarding-adult-reviews) have highlighted missed opportunities in numerous cases for practitioners from different disciplines to come together to share information, discuss and work cohesively with individuals who have multiple issues. This has led to fragmented risk management and care planning for individuals that don’t need a formal safeguarding enquiry response.

This protocol has been written to help provide a meeting framework for practitioners of all disciplines to meet to coordinate actions to address multiple issues, to improve the outcomes for the individual.

**What is a multi-disciplinary team (MDT)?**

Multidisciplinary teams (MDTs) are the mechanism for organising and coordinating health and care services to meet the needs of individuals with care and support needs.

The teams bring together the expertise and skills of professionals from a variety of agencies, and with different backgrounds and experience, to assess, plan and manage care jointly. MDTs must work proactively to support individuals’ care goals.

Through accessing a range of health, social care and other community services, MDTs focus on keeping people well and independent, delivering the right care and support at home or in the community to prevent unnecessary hospital admission.

The MDT meeting requires professionals and practitioners from across different sectors to work together around the needs of Adults, their families and their communities. Whilst MDT meetings are traditionally used to support an individual’s health needs, they can also be an effective tool in identifying and addressing risk caused by multiple needs impacting on an individual’s well-being. An MDT meeting provides an opportunity for a structured conversation about an adult who has complex issues, involving a range of practitioners. Each practitioner brings their knowledge about the person and / or their area of specialist knowledge, to inform all professionals involved with an individual of the full picture, to enable coordination and jointly create an action plan to help manage multiple complexities.

MDT meetings work best when they are well structured, with a clear agenda, membership, roles and responsibilities. Each MDT case review meeting is different in order to suit the people involved (both those attending and those being discussed). This guidance document provides general suggestions to maximise the value of MDT meeting.

**What are the benefits of an MDT approach with individuals with multiple social, environmental, economic and health needs?**

MDT approaches with individuals who face multiple issues in their lives can improve outcomes for people who use services, including:

* Better information sharing to understand the multiple issues facing an individual that may be impacting on their engagement with support
* Better understanding where there may be barriers to treatment planning and compliance
* Better understanding of risks and shared action plans to address concerns to prevent escalation
* Potential reduction in service utilisation (hospital admission, A&E attendance, readmission and length of stay)
* Less duplication of services provided at home or close to home
* Greater self-management and better preventative care to stay well
* Improved service user experience
* People’s engagement and activation through social prescribing and shared decision-making
* Greater continuity of care and support across different care settings.

**What support and conditions do MDTs need to fulfil their role?**

For MDTs to succeed with care coordination and management, a number of enablers and contextual factors need to be in place. These include:

* Trusting relationships across teams
* A shared vision of integrated care and support with clear goals
* Strong service systems and team leadership, accompanied by consistent working practices and protocols
* Good access to shared resources across partner organisations
* A broad range of community-based services from which to provide proactive care management
* Opportunities for informal communication and reflective team learning
* Identified professional taking responsibility for each action
* Each agency sharing relevant information in a timely manner.
* Specific training and professional development, especially joint training within the team
* A good mix of professional backgrounds and boundary-spanning roles, and
* Involvement of service users and/or their carers in care planning and decision-making.

**Structure of MDT case review meetings and suggested Membership**

The membership of the multidisciplinary team can be varied and will depend on the context. Practitioners need to consider who can help and invite as wide a membership as possible. It may be that the team starts small and builds momentum. No one size fits all. An effective team is probably more important than ticking all the boxes. Teams that work well together are those where each member is clear on their roles and responsibilities and where there are clear goals and a supportive environment that allows people to raise concerns safely.

**Membership of MDT meeting could include (not an explicit list):**

* The individual and /or an advocate
* Social Care Professionals
* Health Professionals
* Police
* Greater Manchester Fire and Rescue Service
* Mental Health Services
* Housing services
* Specialist doctors
* Occupational Therapists
* Drug and alcohol services
* Commissioners
* Environmental services
* Representatives of the voluntary sector
* Faith groups
* Family or friends who can offer the individual support

**Suggested Frequency**

It is suggested that MDT meetings are scheduled in advance to take place as frequent as is necessary, with a minimum of once a month being considered, and ideally be face-to-face meetings where possible, meeting more often is not discouraged but can be hard to sustain.

**Suggested MDT roles and responsibilities**

* The Chair is whoever calls the MDT meeting, this can be any professional from any organisation involved with the individual.
* Identify Partners/Professionals who are involved with the person and invite to the MDT meeting.
* There will be a requirement ~~t~~o coordinate and prepare for the MDT meeting inclusive of sending out meeting invites, keeping a record of attendance at each MDT meeting, taking notes of the meeting including all actions agreed, by whom and when, and distribution of the minutes to the Chair for signoff and sending out to participants at the MDT.

**Suggested Agenda**

Standing items may be introduced to the agenda to support the sharing of information. A suggested agenda is available below.

**The MDT meeting**

* Chair - ask each person to introduce themselves and their role in the MDT meeting.
* Ensure there is a clear agenda which supports a structured meeting, allowing for open discussions and safe challenge.
* MDT Team members are required to attend meetings prepared with the relevant information
* There is an expectation that participation in discussions is active and constructive
* Participants are requested to maintain a person-centred, not organisational, focus
* Actions from the previous meeting are reported on.
* Participants are required to share any relevant information that will support the meeting, with the MDT members.
* All participants commit to carry out agreed tasks within agreed timeframes.
* The Chair will summarise decisions and ensure they are recorded accurately.
* Ensure that any actions given to absent team members are conveyed to them in a timely and clear manner.

**Evaluating your MDT**

It may be beneficial to decide how to assess the usefulness of the MDT approach and the impact this has had on the Adult and their family.

An evaluation could involve, for example, case review at 3, 6 and 12 months, or interventions by type.

**Agenda**

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| --- | --- |
| Suggested MDT agenda |  |

**MRM principles**



**Introduction**

This document describes guidance for conducting the Multi-Agency Risk Management (MRM) process and should be read alongside the Rochdale Borough Multi-Agency Adult Safeguarding Procedures.

This guidance must only to be used where the adult:

* Has the mental capacity to understand the risks posed to them
* Continues to place themselves at risk of serious harm or death
* Refuses or is unable to engage with health and social care services.

If the Adult does not have mental capacity the MRM process is **NOT** appropriate and Best Interests Decision Making processes should be followed. However, if there is doubt about the capacity of the individual, then the MRM process can be followed **but only** until it is established that an individual does not have capacity.

It is essential to note that the adult must be considered to have need for care and support in line with the definition contained within the Care Act (2014); Care & Support Statutory Guidance and the Care & Support (Eligibility Criteria) Regulations (2015):

(a) The adult’s needs arise from or are related to a physical or mental impairment or illness

(b) As a result of the adult’s needs the adult is unable to achieve two or more of the outcomes specified as a consequence there is, or is likely to be, a significant impact on the adult’s well-being.

If the risk(s) is not at a level which may lead to serious harm or death the MRM process does not apply and should not be followed. Where the adult lacks capacity the Mental Capacity Act (2005) should take over and action should be taken under Best Interests (See the MRM Principles on Page 4).

The MRM may be applicable in any of the following:

* The inability or unwillingness to care for self and environment, including hoarding
* Refusal of essential services
* Failure to protect self from abuse by a third party (where “mainstream” adult safeguarding processes are not applicable or sufficient to mitigate or eradicate the risk).

An example of not being able to protect self from abuse by a third party may be where it has not been possible to engage the adult with services but their behaviours are placing them at risk of serious exploitation, harm or death. Examples of this type of situation can include the exploitation of adults in situations of sexual abuse, coercion to sell drugs, financial control by others or where their accommodation has been taken over by others.

Case scenarios where the MRM Guidance may apply are included in Appendix 8.

Subject matter expertise, and the inclusion of the Police in these types of situation are vital in order that all available intelligence is shared to support the achievement of proportionate, accurate and effective decision making and forward risk planning.

The guidance should be used flexibly and in a way that achieves best outcomes for the adult. It does not, for example, specify which professionals need to be involved in the process, or prescribe any specific actions that may need to be taken as this will be decided on a “case by case” basis through coordinated multi-agency working; in line with:

* Making Safeguarding Personal (MSP) principles
* Information sharing protocols
* Rochdale Borough Safeguarding Adults Multi-Agency Policy and Procedures
* Human Rights Act 1998
* The Care Act 2014
* Data Protection Act 1998 (General Data Protection Regulations 2018)
* Care & Support Statutory Guidance

**Safeguarding principles**

Six key principles underpin all adult safeguarding work:

**Empowerment** – Personalisation and the presumption of person-led 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** – Proportionate and least intrusive response appropriate to the risk presented.

*“I am sure that the professionals will work for my best interests, 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. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”*

**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 professionals treat any personal and sensitive information in confidence, only sharing what is necessary. I am confident that professionals will work together to get the best result for me.”*

**Accountability** – Accountability and transparency in delivering safeguarding.

*“I understand the role of everyone involved in my life.”*

**When is the MRM applicable?**

The MRM protocol can be used where there is documented evidence that an adult refuses to engage with the s42 safeguarding process, and where evidence suggests they are at risk of serious harm or death.

The MRM protocol should only be applied in the following circumstances:

* The adult has care and support needs (whether or not the local authority is meeting any of those needs) and is experiencing, or is at risk of, abuse, neglect or self-neglect.
* As a result of their care and support needs the adult is unable to protect themselves from either the risk of, or the experience of, abuse or neglect;
* The adult **has** mental capacity to make unwise decisions and choices about their life.
* The adult’s decision making places them at risk of serious harm from self or others.
* There is documented evidence that the adult is not engaging with health and social care services to reduce the risk of harm or death.

For the purposes of the MRM protocol, serious harm (physical or psychological) is that which is life-threatening and/or traumatic and is viewed to be imminent or very likely to occur.

Consideration should also be given to the following circumstances:

* There is a **public safety** interest.
* There is a high level of **concern from partner agencies.**
* Where all **interventions, protection and actions plans have failed to safeguard** the adult.

**Scoping the MRM Risk Action Planning meeting**

Any agency can initiate a MRM risk action planning meeting. The expectation is that the agency’s Safeguarding Leads will exercise professional judgement when referring a case to this process. The agency that identifies the need for a MRM risk action planning meeting will both lead and co-ordinate the MRM process.

Consent for holding a MRM risk action planning meeting should be obtained from the adult wherever possible and the adult should be encouraged to participate in the MRM process. However, a lack of consent does not prevent a MRM risk action-planning meeting from taking place. Under common law a person may act to prevent serious harm from occurring if there is a necessity to do so.

Depending on the urgency of the situation, it may be necessary for professionals to prioritise the MRM risk action planning meeting. Invitees will be determined on a “case by case” basis but should involve representatives from all key agencies who are or should be linked to the case; this may include the Police as they may hold relevant intelligence, and other agencies such as health professionals, Greater Manchester Fire and Rescue Service (GMFRS) or housing services. The Chair of the MRM risk action planning meeting will be a senior manager.

When scoping invitees, consideration should be given to which person might be best to engage with and work effectively with the adult – this person may not necessarily be a professional from one of the key agencies, for example, this could be someone from a voluntary agency, such as an outreach worker. When scoping attendees choose people that can make decisions at the meeting rather than taking them away to get approval.

In all cases the adult should be invited to attend the MRM risk action planning meeting, with an advocate or interpreter as appropriate. Where applicable, family members and/or other representatives directly involved with the adult should also be invited to attend or to submit any relevant information in advance if they are unable to attend for any reason.

The Principal Social Worker and Strategic Safeguarding Lead is available for advice and guidance at any stage.

***“There is strong professional commitment to autonomy in decision making and to the importance of supporting the individual’s right to choose their own way of life, although other value positions, such as the promotion of dignity, or a duty of care, are sometimes also advanced as a rationale for interventions that are not explicitly sought by the individual”*** *SCIE Report 46 (2001).*

**The MRM Risk Action Planning Meeting**

Once it has been agreed that the MRM process is appropriate the following steps should be taken to hold a multi-agency risk management meeting:

|  | **Action**  |
| --- | --- |
| 1 | Email the Principal Social Worker and Strategic Safeguarding lead (TAS@rochdale.gov.uk) informing them of the decision to hold an MRM risk action planning meeting and give details of name, date of birth, ALLIS or NHS number and date of planned meeting. |
| 2 | The Adult Risk Management Tool and checklist of considerations (Appendix 1) should be completed/updated in preparation for the MRM meeting. |
| 3 | Capacity or lack of capacity is a vital element in risk action planning with, or on behalf of, adults who are at risk of self-neglect. Therefore, the adult’s mental capacity in respect of the specific concerns associated with the case and their consent should be discussed and confirmed at the beginning of each MRM risk action planning meeting. This should be informed by any information gathered at the meeting where not able to complete a formal MCA.  |
|  | The line manager should identify a senior manager in their organisation to chair the MRM risk action planning meeting. Name and contact details to be emailed to TAS@rochdale.gov.uk  |
| 4 | If a key agency does not nominate an officer to attend, every effort should be made by the senior manager nominated to chair the meeting to ensure attendance. If this fails the issue should be escalated to directorate level for resolution. |
| 5 | The meeting should identify the immediate risks and produce a risk action plan (Appendix 4). The meeting should focus on the information contained in the Risk Management Tool (Appendix 1). The case worker should summarise the information and provide relevant documents to enable (a) significant risks to be identified, and (b) key actions to be identified. |
| 6 | The Chair of the meeting should ensure that minutes of the meeting (template in Appendix 6), including the risk action plan are confirmed as accurate and request the minute taker to circulated to attendees within 5 working days and should be uploaded to the individual’s electronic case record. |
| 7 | If there have been three MRM meetings within a six month period and the risk remain, the chair of the meeting should ensure that attendees from the organisations represented escalate to the senior members of their agencies and Adult Care should add this to the next ACSPB agenda  |

Once it is clear that the adult concerned has capacity to understand the consequences of refusing or disengaging from services, participants of the risk action planning meeting, in developing a MRM Risk Action Plan (Appendix 4) should follow the framework factors given below:

1. Confirm the coordinating Adult Social Care Social Worker and who will be the key contact with the adult concerned (these may not be the same person in both roles).
2. There will not always be a mental capacity assessment completed, there will be times when capacity is assumed, therefore record discussions about capacity with any rationale why the adult has capacity. If a capacity assessment has been carried out record when, where and by whom the capacity assessment was carried out. Where the information suggests the adult’s capacity may have changed consideration of how to evidence capacity should be given and recorded.
3. Document the adult’s level of involvement and, where known, their desired outcomes.
4. Record what needs to change to support safety and reduce risk.
5. Consider and record all attempts that have been made to engage the adult.
6. Ensure that all applicable agencies are actively involved if they aren’t already, this can include for example:
* General Practitioner (GP)
* Children’s Social Care
* Greater Manchester Fire & Rescue Service (GMFRS)
* Housing and Homelessness Services
* Drug & Alcohol Services
* Domestic Abuse Support Services
* North West Ambulance Service
* Northern Care Alliance
* Pennine Care NHS Foundation Trust
* Greater Manchester Police (GMP)
* Rochdale Adult Care
* Community Services etc.
* Voluntary and third sector organisations involved with the individual (NB: this is NOT an exhaustive list).
1. Professionals should also consider and confirm, as applicable and appropriate, the support that carers, family members, children or other adults at risk might need, and again consider who is best placed to engage and support them.
2. Develop the MRM Risk Action Plan (Appendix 4) with clear actions, timescales and responsibilities.
3. Document contingency planning arrangements to be instigated if the MRM Risk Action Plan is unsuccessful.
4. Set realistic review dates and times.
5. If there have been three MRM meetings within a six month period and the risk remain, the chair of the meeting should ensure that attendees from the organisations represented escalate to the senior members of their agencies and Adult Care should add this to the next ACSPB agenda
6. Meeting notes should be stored on the individual’s electronic record.

The Risk Action Plan should be shared with the adult, and signed by them, if they did not attend the meeting.

**Inherent Jurisdiction**

Adults who have capacity to make decisions which may result in them placing themselves at risk of significant harm or death may require further judicial intervention to ensure their safety. This is most likely to occur if the adult continually fails to engage with professionals and all other options have been exhausted.

There may be occasions when the Courts are prepared to intervene in the case of an adult, even when they have the capacity to consent, for example, where an adult is receiving undue pressure or coercion from a third party. The Court’s purpose is not to overrule the wishes of an adult with capacity, but to ensure that the adult is making decisions freely.

Legal advice should always be sought when Inherent Jurisdiction may be a factor.

**Timescales**

It is important to agree timescales for each part of the MRM risk action planning process to prevent drift. This will be different for each case dependent on individual circumstances.

It is also important to ensure that any decisions made are accurately recorded.

Within the MRM Risk Action Plan, it should be clear what the identified risks are, what the agreed actions are, who is responsible for carrying out the actions and the timescales involved. Disagreements should also be clearly documented.

**Review**

A decision should be taken about when to undertake a review, this should be based on the level of risk presented. The MRM risk action planning meeting (see Appendix 7 for review meeting template) should reconvene to discuss the Risk Action Plan.

The process should continue until it is felt that the adult is engaging with services for as long as risk remains critical.

1. Confirm if urgent actions have been taken or are further required:
* to meet the needs of children, other adults at risk or animals living or involved with the adult
* Public or environmental health concerns
* Criminal activity

1. Re-establish and confirm mental capacity (including as applicable issues of fluctuations in capacity, and/or advance decision making), and information sharing arrangements
2. Ensure an independent advocate is available to the adult
3. Convene a MRM risk action planning review meeting
4. Review the MRM Risk Action plan and update with new actions
5. Test engagement and improved outcomes.
6. If more than 3 MRM meetings are held in a six-month period and the risk is not reducing, the case should be escalated by the attendees to their senior management teams for discussion at senior management level. In Adult Care the chair should arrange for the case to be discussed by Adult Care senior leadership team.

**Escalation of concerns**

The Chair of the MRM risk action planning meeting holds responsibility for the escalation of concerns as required.

It is recognised that at times there will be disagreements over the handling of concerns. These disagreements typically occur when:

* The adult is not considered to meet eligibility criteria for assessment or services
* There is disagreement as to whether safeguarding adult procedures should be invoked
* There is dispute about the adult’s mental capacity to make specific decisions about managing risks
* The adult is deemed to have mental capacity to make specific decisions and is considered to be making unwise decisions
* Professionals place different interpretations on the need for single/joint agency responses
* Professionals feel that meeting the needs of the adult sits outside of their work remit
* Resources are not appropriately available or allocated, it must be noted that at all times actions are required to be taken within the law and to not be constrained due to perceived limitations to organisational boundaries.

Professionals involved in this process should always try to work out their differences. Where there are irreconcilable and significant differences between professionals however, consideration should be given to including an agreed neutral third party. It may also be necessary to consider escalating the case to more senior decision makers within organisations. In any case, the case should be escalate to senior managers if 3 MRM meetings take place in a six month period.

**Information Sharing**

Information sharing will be in line with local Information Sharing Protocols.

**Protection v Self Determination**

The dilemma of managing the balance between protecting adults at risk from self-neglect against their right to self-determination is a difficult challenge for all services. Example case scenarios are included within Appendix 9.

This process does not, and should not, affect an individual’s human rights, but seek to ensure that the relevant agencies exercise their duty of care in a robust manner and as far as is reasonable and proportionate.

Applying this process should ensure all reasonable steps are taken to ensure safety, by a multi-agency group of professionals. This model will be critical for the reasons outlined above, but in addition will anticipate the possible extension of the definition of adults who may be in need of safeguarding (to include those at risk of harm as a result of self-harm/self-neglect).

Where possible, the adult’s views and wishes/desired outcomes should be included and if they are not present, there should be detailed reasons for this.

**Case Closure**

When working with an adult under the MRM protocol, there must be agreement by all professionals involved in the case that the adult is engaging and no longer at risk of serious harm or death before the process is ended. It should be understood by all agencies that a case under the MRM protocol may be open for a considerable period of time.

The main reasons for closure include:

* The adult is now engaging with professionals to reduce risks
* The risk is reduced to a level that there is no longer a risk of significant harm or death
* The adult is deceased.

Before a case is closed, even if the individual has died, a review of the case must be held to determine:

* the rationale for closure, to capture the individual’s outcomes
* if there is any learning from the case
* if a multi-agency review following the Adult Care Unexpected Death Procedure is needed
* whether a Safeguarding Adult Review referral is needed.

The closure summary (appendix 9) must be completed when a case is closed for any reason (death, engagement etc.) The responses will help identify any actions still outstanding and to process and collate themes and outcomes for people managed through the MRM process.

Once completed the form should be sent to TAS@rochdale.gov.uk and to the relevant Safeguarding Lead in your agency.

# Quality and Practice Assurance

Quality and practice assurance plays a significant role in ensuring that the MRM process is governed effectively whilst identifying trends and training needs. Rochdale Borough Council in line with the RBSAB will be working closely with relevant partner agencies through the MRM Executive group to monitor and report on:

* Number of adults going through the MRM and review process
* Audit/ Quality control
* Escalation processes
* Outcomes.

**Appendices**

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| **Appendix 1**Risk Management Tool (*including checklist of considerations)* |  |
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