Safeguarding Adults Review (SAR) Guidance Document

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Cumbria Safeguarding Adults Board

Contents

The purpose of this document is:

- To provide clear guidance for individuals, families, professionals and partner organisations regarding processes relating to Safeguarding Adults Reviews (SARs).
- To ensure that local practice is in line with the Care Act 2014 statutory requirements for the Cumbria Safeguarding Adults Board (CSAB) to undertake SARs.
- To provide a framework that enables SARs to be undertaken in a proportionate way with the primary aim of multi-agency learning.
- To recognise that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews) and the importance of managing the interface between these and a SAR.
- To recognise that the adult and/or their family must always be offered the opportunity to contribute to the review process and are provided with the appropriate support to do so. This may include involving a Care Act advocate.

1. Introduction

1.1 The Care Act 2014 introduced a number of new duties with regard to Safeguarding Adults. One of these duties is that the Safeguarding Adults Board (SAB) must undertake a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is reasonable cause for concern about the way agencies worked together to safeguarding the individual (s44). The SAB must also undertake a SAR if an adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.2 The SAB should be primarily concerned with weighing up what type of review process will promote effective learning and improvement action to prevent future deaths or serious harm occurring.

1.3 The SAB can also exercise discretion and undertake a "Learning Review" (appendix 3) in other situations, where it feels a case does not meet the statutory criteria (see 2 below) but there are lessons to be learned which may improve and strengthen multi-agency working.

1.4 Members of the SAB are required to co-operate and contribute to the carrying out of a review by sharing information and applying the lessons learned. The Care Act (s45) also enables the SAB to request relevant information from anyone in order to support it in undertaking a review.

1.5 Every review should take into account what was known to practitioners working with the individual or could have reasonably been expected to be known by them at the time. Consideration should also be given to the capacity of the person at risk and their views and choices.

1.6 SARs are not enquiries into how an adult at risk died or who is culpable. SARs are an opportunity to consider how agencies worked together, to share lessons learnt so that we can further improve the way we work together with adults at risk of abuse or neglect.

1.7 This guidance reflects the six key safeguarding principles that underpin all adult safeguarding work.

Empowerment	People being supported and encouraged to make their own decisions and informed consent
Prevention	It is better to take action before harm occurs
Proportionality	The least intrusive response appropriate to the risk presented
Protection	Support and representation for those in greatest need
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
Accountability	Accountability and transparency in delivering safeguarding

2. SAR statutory criteria (Care Act 2014)

In accordance with s44, Cumbria Safeguarding Adults Board (CSAB) must arrange a SAR for an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if;

a) There is reasonable cause for concern about how CSAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**
b) condition 1 or 2 below is met,

Condition 1

a) the adult has died, **and**
b) CSAB knows or suspects that the death resulted from abuse or neglect.

Condition 2

a) the adult is still alive, **and**
b) CSAB knows or suspects that the adult has experienced serious abuse or neglect significant harm* or reduced quality of life.

*"Significant Harm" - for the purposes of the SAR criteria, significant harm is defined as a life limiting incident (including psychological harm) from which there will be no recovery.

2.1 CSAB can exercise discretion and arrange a Learning Review of any other case involving an adult in its area where it believes that there will be value in doing so. This may include where an agency believes there are lessons to be learned for all involved which will improve multi agency working*, practice and information sharing. Referrals which do not meet the statutory criteria will be considered in the same way and decisions including rationale communicated by Chair of the SAR sub group.

*"multi agency working" – reason to believe there are concerns regarding multi agency working which would otherwise have offered protection (involving 2 or more agencies).

3. What is the purpose of a Safeguarding Adults Review

3.1 The statutory guidance for the Care Act describes the purpose of a SAR as being "to promote effective learning and improvement action to prevent future deaths or serious harm occurring again". The aim of every review should therefore be, to learn lessons from the case and to make sure that those lessons are applied to future cases by all agencies in Cumbria to prevent similar harm occurring.

3.2 It is not the role of a SAR to hold any individual or organisation to account. There are other processes which exist for this purpose including; criminal proceedings, disciplinary processes, employment law and regulations systems for both services and professionals (Care Quality Commission, the Nursing and Midwifery Council or the Health and Care Professionals Council).

4. Requesting a Safeguarding Adults Review

4.1 A request for a referral can be made by;

- Any organisation/agency working with adults in Cumbria
- Any professional from the Board's partner agencies
- The individual concerned, a family member or another interested partner such as the Coroner or Member of Parliament

4.2 The following considerations should be made when deciding whether to request a review;

- The concern relates to an adult with needs for care or support – whether or not they are/were in receipt of services
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused
- There are concerns about failings relating to 2 or more organisations working with the individual and the potential to identify and improve multi-agency practice and partnership working

4.3 The referring agency must ensure that a discussion has taken place with their safeguarding lead, who will advise them. The referring agency may want to consider discussing the matter with the other agencies and consider submitting a joint referral, or it may be prudent initially to conduct an informal information gathering meeting involving those agencies, in order to obtain a clear picture to inform the referral process.

4.4 There will be situations where an incident has triggered an internal or organisational process. Organisational investigations should take place without delay, but as part of their internal mandatory investigation or review process the organisation should consider a SAR referral if;

- The investigation has highlighted concerns about another organisation or how people worked together.
- Information has come to light during the investigation that identifies abuse or neglect that was not previously recognised

4.5 Some requests may relate to people who are also subject to other statutory review processes such as a Domestic Homicide Review (DHR), Mental Health Homicide Review, MAPPA review or a Children's Serious Case Review. Further information regarding parallel statutory review processes are detailed in (appendix 4). In these circumstances, the referral should highlight the links to any other reviews taking place. The SAR sub group will agree how the interface with other such reviews should be managed.

4.6. The adult or their family should be made aware of any intended request by the referring organisation/individual and be provided with the opportunity to give their views about the request.

4.7. SARs do not form part of any disciplinary process. However, if there are disciplinary matters in progress regarding the situation being requested for consideration, this information should be noted on the referral form including contact details.

4.8. To make a request for a SAR the referral and decision form should be completed (appendix 1) and sent to CSAB@cumberland.gov.uk

5. The decision making process

Step by step process;

5.1 Once a SAR referral form (appendix 1) is received the Board Business Manager will inform the Chair of the SAR sub-group. The CSAB Independent Chair will also be informed for information.

5.2 The referral will be presented by referring agency to the SAR sub-group bi-monthly meeting. This should be within 14 days of receiving the referral. However, an extra-ordinary meeting/discussion will be convened if timescales require such. This meeting/discussion must comprise of at least 1 representative from each of the following; Cumbria County Council, NHS Trust (Provider), Clinical Commissioning Group and Cumbria Police.

5.3 The SAR Sub group will assess whether or not the referral meets the statutory criteria set out in (2) above. A brief overview, including decisions of the meeting/discussion should be recorded in the decision section of the SAR Referral and Decision template (appendix 1).

5.4 If additional information is required, this will be requested by the Business Manager from appropriate agencies involved using a Case Information form detailing key information (appendix 2) along with a chronology of significant events (spread sheet template provided) The SAR sub group should agree the time frame for agency chronologies to detail. The requested case information and chronologies should be returned to the CSAB Business Manager within 21 days for review by the SAR sub group.

5.5 Agency case information and a full collated chronology of events during the agreed time period will be reviewed by the SAR sub group. The SAR sub group will consider alongside any other learning and reviews which may be ongoing e.g. DHR, STEIS, Children's SCR, Complaints (appendix 4). Consideration should be given to the interface between reviews and how these will be managed to ensure learning can be shared.

5.6 The SAR sub group via the Chair will then make a recommendation to the Independent Chair of CSAB on behalf of the group as to whether the case meets the statutory criteria, methodology for review, proposed Chair/Facilitator for Review Group – noted on SAR Referral & Decision template (appendix 1).

5.7 The CSAB Chair will consider recommendations made along with any supporting information shared and note their decision on the form. Note; where it is timely for a decision to be made by the CSAB this will be included as an agenda item but should not invoke any delay in process. The final decision as to whether to proceed to a review will be made by the Chair of the Safeguarding Adults Board.

5.8 At each of the above steps the SAR Referral & Decision form should be shared with the Board Manager for logging and effective tracking of the process.

5.9 Where it is agreed the referral does not meet the criteria for an SAR, the Chair of the SAR sub-group will write to the referrer explaining the reasons why not. Where appropriate the individual and family should also be informed of the decision by the referrer.

5.10 If a referral does met the criteria for a SAR the CSAB Chair and SAR sub group Chair should agree on the following; methodology, Chair/Facilitator for the review, Terms of Reference (appendix 5) and Review Group membership. Terms of Reference for the Review Group will also consider how the SAR process will dovetail with any other relevant investigations which are running parallel (appendix 4).

6. Safeguarding Adults Reviews – methodologies

6.1 The approach adopted for the review should ensure learning can be disseminated and acted upon in a timely manner.

6.2 There are many ways that learning can be obtained, but the review must be proportionate in the approach it takes. The methodology to be used for a review will be discussed by the SAR sub group with a recommendation about the most appropriate learning method for the case under consideration made to the CSAB Chair.

6.3 A summary of the approaches and methodologies that can be used are contained in appendix 3. It is recognised that the list is not exhaustive and the SAR sub group may wish to use its collective expertise to recommend alternative approaches.

7. The SAR Sub Group's responsibilities for Safeguarding Adults Reviews

7.1 Discussion and agreement with the CSAB Chair on behalf of the Board and SAR sub group Chair will define and agree expectations of the review.

This will ensure that a clear brief can be provided to all with expectations and should include the following;

- Methodology for review (most effective to facilitate learning)
- An author/facilitator for the review
- Terms of Reference for a Review Group (appendix 5)
- What documentation is expected as outputs; overview reports, executive summaries, lessons learned, action plans etc.
- Identify and agree the agencies that should be involved in the SAR
- Agree who will be responsible for communicating with the adult and/or their family or advocate
- Consider if it would be appropriate to communicate with the person who is alleged to have caused the abuse or neglect

- Agree a reasonable timescale for completion of the SAR which in any event should be within a 6 month period.
- Communication to the Review group and independent facilitator/author to provide a clear brief and set out requirements/expectations.

7.2 For reviews which meet the statutory requirements, the person leading the review must be external to any of the agencies and partners of CSAB.

Where a referral does not meet the statutory criteria for SAR it may be appropriate to undertake a Learning Review (please refer to 2.1 (appendix 3).

Learning Reviews can be undertaken by any individual/professional providing they have the skills required to undertake the review or work for an organisation not involved in the review.

7.3 The SAR sub group will receive regular updates on the progress of the SAR from the Review Group as set out in the terms of reference.

7.4 The Chair of the SAR sub group will ensure that progress updates are provided to the Safeguarding Adults Board at its scheduled meetings.

7.5 The draft final report together with a draft action plan will be presented to both the SAR sub-group and the CSAB Chair.

7.6 The Chair of the SAR sub group, supported by the Board Business Manager, will ensure that the final report is presented to the Board as soon as possible after its completion.

7.7 The Chair of the SAR sub group will also agree with the Review Group Chair how the draft report is to be shared with the individual and/or or their friends or relatives.

7.8 The SAR sub group will be responsible for identifying which other sub groups will take responsibility for obtaining assurance on each aspect of the plan. This assurance will include confirmation that the required steps have been taken and the lessons learnt have been shared across organisations in Cumbria. These actions will be monitored by the SAR Sub Group through the Board's Strategic Plan.

7.9 The Chair of the SAR sub group will provide updates to CSAB on the progress of the action plan and agree with CSAB when a review should be closed further to all actions completed.

8. Role of the Person appointed to lead the Safeguarding Adults Review

8.1 The person leading the SAR will be accountable to the SAR sub group during the period of the review.

8.2 It is expected that a person leading/chairing a review will have the appropriate skills and experience to lead a review, as outlined in the Care Act guidance. These include;

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

8.3 The person leading the review will be responsible for;

- Achieving consensus of opinion about the key areas of learning and/or areas of change identified
- Ensuring that agency representatives work together positively
- Ensuring that an appropriate level of challenge is provided throughout the process
- Identifying good practice as well as areas of development and including both in the report
- Agreeing with agencies and the Chair of the SAR sub group who will be the named individual responsible for contact with the individual or family members and how the individual or their families/friends will contribute to the review
- Keeping the SAR sub group Chair updated on the progress of the review.

8.4 The person leading the review is also responsible for writing the review report ensuring that it;

- Is in plain English
- Clearly identifies the learning points and recommendations being as “SMART” (Specific, Measurable, Achievable, Relevant and Time-bound) as possible.
- Is suitable for publication without needing to be amended or redacted.

8.5 Once the report is written, the person leading the review is responsible for seeking agreement from all contributing agencies that they are satisfied that the report reflects the information shared and discussions held as part of the review. If it is not possible to obtain agreement, the person leading the review has the final decision on what is written. The Chair of the Safeguarding Adults Board should be notified where agreement has not been obtained from all agencies

8.6 The person leading the review is also responsible for;

- Agreeing with the SAR sub group Chair and the CSAB Chair how the report will be shared with Board members and the individual and/or family
- Participating in any agreed communication arrangements regarding the report, including public information.

9. Undertaking a Safeguarding Adults Review

9.1 The person leading the SAR will have access to CSAB Administrative and Business Management support.

9.2 The selected methodology will affect the level of multi-agency meetings required to complete a review. Each agency will provide information as required.

9.3 The person leading the SAR will agree with all agencies involved how records will be presented during the review process. This may require reports that are anonymised through redaction, and an agreement made on the abbreviations to be used by all agencies. It may be that consent is obtained from the individual/family that their information can be shared in an un-redacted form during the review process.

9.4 Agencies must be aware that there could be public scrutiny of information provided to the review. All agencies should therefore ensure that their submissions are approved by their organisation before they are shared with the review. This may if considered appropriate, include obtaining legal advice prior to submission.

9.5 The report produced at the conclusion of the SAR will be anonymised with regard to individuals – including the individual, their families and professionals. All agency names and job roles will also be anonymised.

9.6 The final draft report will include recommendations which should be reflected in the action plan provided together with the report.

10. Timescales for a Safeguarding Adults Review

10.1 A review must be undertaken in a timely manner. The process detailed above should be completed within six months of the decision being made that a review is to be undertaken.

10.2 It is recognised that there may be occasions when the issues being considered by the review may mean that a longer timescale is needed. In these situations the person leading the review must agree the revised timescale with the SAR sub group and CSAB Chairs.

10.3 If during a review, issues regarding criminal actions or the safety of a service are identified, these should be immediately shared with the appropriate authority. The person leading the review must inform the Chair of the SAR sub group and the CSAB Chair to agree any changes required to the timescale or the scope of the review.

11. Sharing

11.1 Section 44.5 requires organisations and partners represented on CSAB to co-operate in and contribute to the carrying out of a SAR with a view to identifying the lessons to be learnt from the adult's case and applying those lessons to future cases.

11.2 Section 45 places a legal duty on any organisation or individual asked to provide relevant information to share what they know with CSAB or the person identified (i.e. the person leading the review). This section applies if the information being requested on behalf of the Board is to enable or assist it to perform its functions. Undertaking a SAR is a function of the Board and therefore s 45 applies to all requests for relevant information made as part of the Safeguarding Adults Review process.

Note; In order to carry out functions SABs will need access to information a wide number of people and/or organisations hold. These may or may not be SAB members. However, as above Section 45 places a legal duty for all requests to be responded to if the information is required in order for a SAB to carry its duties, one of these being a SAR irrespective if the organisation are members or not to their local SAB.

12. Use of an independent advocate

12.1 An independent advocate must be provided to support and represent adult (where the adult is still alive), who is subject to a safeguarding review if;

- It is considered the person would experience substantial difficulty in participating in the review person and
- They do not have an appropriate person (friend or family) that could support their involvement in the review

12.2 If the person already has a Care Act Advocate or an IMCA, unless inappropriate, this advocate should be used.

13. Involvement of Families

13.1 Families should be informed if a review is going to take place. They should be offered the opportunity of contributing to the review process, but how that is done will depend on the methodology used and the views of the family.

13.2 It is the role of the person leading the review to ensure that an individual is identified to be the contact with the family or person. The person leading the review will also agree the manner in which family members or friends will contribute to the review if they wish to do so.

13.3 The consent of the family or individual is not however required for a review to take place.

14. Responsibility to staff

14.1 Staff directly involved in working with an individual subject to a SAR should be notified by their employing agency that the decision has been made to undertake the review.

14.2 Information about the review process and how the staff members may be involved in the review should be fully explained by their employing organisation.

14.3 Support to staff members should be provided by the employing agency/organisation in line with their HR requirements.

14.4 Agencies may also need to consider what support is required if a systems approach is used to undertake the review, as this approach requires a high level of reflection and interaction from individuals. Whilst the outcomes of this approach should be very positive, individuals can experience it as being challenging.

15. Final Report and Action Plan

15.1 All SAR reports are owned by Cumbria Safeguarding Adults Board. The report and action plan are only final when accepted and approved by the Board.

15.2 Prior to publication CSAB should consider the impact of publication and consult with partner Communication Leads.

15.3 The action plan will explicitly set out how agencies will evidence that actions have been completed and how the learning from the SAR will be embedded into practice.

15.4 CSAB will be provided with updates on the action plan and a review will only be closed when the Board is satisfied that all the actions have been completed.

15.5 SAR reports will be published on the CSAB website along with a learning brief.

15.6 Prior to publication the Safeguarding Adults Board Chair will co- ordinate the writing of a reactive/proactive statement with partner organisations Communication Leads.

16. Resolving disagreements between Safeguarding Adults Boards (SABs)

16.1 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 outside the provider's area. If that is the case, a SAR should be carried out by the SAB responsible for the location where the serious incident took place. Boards and organisations should co-operate across borders, and requests for the provision of information should be responded to as a priority.

16.2 If agreement cannot be reached on the requirement for a SAR to be undertaken, this will be resolved through discussion with Independent Chairs of the Boards concerned. Independent Chairs will agree on the mechanisms for presenting SARs that have cross border learning.

Appendix 1
Cumbria Safeguarding Adults Board Referral form and Safeguarding Adults Review (SAR) Referral Form

All referrals should in the first instance be discussed with agency Safeguarding Leads. Completed referral forms should be returned to CSAB@cumberland.gov.uk

Please complete all sections using the information held by your agency. Your agency representative will be expected to present the referral to the SAR sub group. All enquiries please contact via above email.

1. Adult's Details			
Name		DoB	
DoD (if applicable)		Date of incident	
Gender		Age	
Ethnicity		Religion	
NHS number (if known)		GP name	
Address of adult			
Other's resident at adult's address			
Address where death/incident took place			
Next of kin			
Other relevant information			

2. Referral Details			
Date of referral		Agency	
Name of referrer		Address	
Telephone number		Email	

3. Agencies you know to be involved *(please provide as much as possible)*			
Agency/Professional	Name, address & telephone number	Date of first contact	Date recent contact
Police			
Health visitor			
GP			
Care/Residential/Nursing Home			
Community Health Provision			
Hospital, Acute NHS Provision			
Adult Social Care			
Children Social Care			
Adult Mental Health Service			
Third Sector Organisation			
Drug / Alcohol Service			
Probation			
Housing			
NW Ambulance Service			
Fire and Rescue			
Other (please specify)			

4. Your agency involvement with the adult *(Briefly outline your agency/service involvement with this case including areas of concerns about other agencies involvement/lack of which may have impacted on incident)*

5. Please outline circumstances of the incident *(including dates/times and locations in chronological order. Also note where any other review is being undertaken as a result of this incident*

6. Safeguarding Adult Review (SAR) Criteria (s44 Care Act 2014). Please describe below how the case meets the statutory criteria

CSAB must arrange a SAR for an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) if;

c) There is reasonable cause for concern about how CSAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**
d) condition 1 or 2 below is met,

Condition 1

c) the adult has died, **and**
d) CSAB knows or suspects that the death resulted from abuse or neglect.

Condition 2

c) the adult is still alive, **and**
d) CSAB knows or suspects that the adult has experienced serious abuse or neglect significant harm* or reduced quality of life.

**"Significant Harm"* - for the purposes of the SAR criteria, significant harm is defined as a life limiting incident (including psychological harm) from which there will be no recovery.

Please explain how and why this case meets the criteria above for a SAR (explanatory notes detailing which of the conditions are met and how)
Are you aware of any of the following in respect of this case □ **Criminal Investigation** □ **Complaint** □ **Internal enquiry** □ **RADAR** □ **Domestic Homicide Review** □ **Serious Case Review (Children)** □ **STEIS** □ **LeDeR** □ **Open Safeguarding enquiries** □ **Any other reviews (please note below)** . . . . .

Is the adult/family/advocate aware that this request for a SAR is being made (if applicable)?

Yes/No *(please delete as applicable)*

Please use the space below to provide any other information which you feel is relevant/will be useful to support decision making

Please explain how and why this case meets the criteria above for a SAR (explanatory notes detailing which of the conditions are met and how)
Are you aware of any of the following in respect of this case □ **Criminal Investigation** □ **Complaint** □ **Internal enquiry** □ **RADAR** □ **Domestic Homicide Review** □ **Serious Case Review (Children)** □ **STEIS** □ **LeDeR** □ **Open Safeguarding enquiries** □ **Any other reviews (please note below)** . . . . .

Is the adult/family/advocate aware that this request for a SAR is being made (if applicable)?

Yes/No *(please delete as applicable)*

Appendix 2

Request for Case Information

Dear agency representative,

Request for case information and chronology involving (name & date of birth)

Cumbria Safeguarding Adults Board has been asked to consider conducting a Safeguarding Adults Review into concerns raised and how agencies worked together prior to (details of incident or death of adult).

The Care Act 2014 placed a statutory duty on the Local Safeguarding Adults Board to arrange a review of an adult in its area with needs for care and support if there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other organisations worked together to safeguard the person **and** condition 1 or 2 below is met;

Condition 1; the adult has died **and** CSAB knows or suspects that the death resulted from abuse or neglect.

Condition 2; the adult is still alive **and** CSAB knows or suspects that the adult has experienced serious abuse or neglect resulting in significant harm or reduced quality

Your agency has been identified as being involved with (name) and to support the Board in the decision making process I am writing to request a brief report of your agency involvement using the case information template attached.

Can I also please ask you to outline a brief chronological explanation of your agency's involvement and contact with (name) and any significant others. Please also include your agency's involvement with other relevant agencies in relation to this case. Please set out the facts chronologically using the excel spreadsheet provided for the period **(date period as determined/agreed by SAR sub group Chair).**

Can I please ask you to complete and return case information and your agency chronology no later than (deadline 21 days of request) to CSAB@cumberland.gov.uk

For your information chronologies have been requested from the following agencies; (list of agencies).

If you require any further information, please contact Simone Eagling, Board Business Manager simone.eagling@cumberland.gov.uk

Yours sincerely

Jeanette McDiarmid - Independent Chair, Cumbria Safeguarding Adults Board

Information is required within 21 days from date of request. Please return case information and chronology of significant events by ***(deadline).***

Name of representative completing	
Organisation/agency	

Details of adult

Name	*This information will be populated before request sent by BM from referral form*
Date of birth	
Address	
GP	

Details of person/s alleged to be responsible for abuse or neglect (if appropriate)

Name	1.	2.
Date of birth		
Address		
Relationship to adult		

A chronology template is also attached. Please complete significant events between the following dates; *(agreed by SAR sub group requesting further information)*

Please provide a brief over view of case record relating to the named adult including any details of records reviewed to complete this, family/and/or other agency involvement.

Appendix 3
Methodologies for Safeguarding Adults Reviews (SARs)

There are many ways to achieve learning and a proportionate response needs to be given to each review. When the SAR sub group is considering which methodology would be most appropriate for a review, they may want to consider the approaches detailed below. It is recognised that this list is not exhaustive and the sub group will use the expertise available to it to recommend the most appropriate learning method for the review.

1. Significant Incident Learning Process (SILP) (Learning Review)

This collaborative and analytical approach can be applied to both statutory and non-statutory (discretionary) reviews. It brings together frontline practitioners, managers and Safeguarding Leads from key agencies involved in an identified case to facilitated events. These facilitated events primarily explore the professional's view of the case around the time which the incident took place. One of the key aims is to focus on why those involved acted in a certain way at the time of events and will include analysis of significant events, what happened and why.

Each review will be scoped to offer a proportionate approach according to the requirements of the case.

Agencies involved are asked to provide chronologies that detail their involvement with the individual within a specified time band. This information is then used to support the discussion during the multi-agency learning event that forms the central aspect of this approach.

Agencies involved will consider significant events within the situation under review to analyse what went well and what could have been done differently to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements.

An external facilitator may be used if the complexity of the case means it is necessary to do so or in event of any conflict of interest. The SAR sub group in conjunction with the CSAB chair will agree Terms of Reference for such a review including a timescale for completion.

This process will involve operational staff and managers who will be required to own the summary of learning at the end of the process with a view to this being disseminated quickly at operational level. However, it should be noted that all learning will be managed at Board level and agency representatives on the CSAB held to account. Other persons involved may also include; authors of the agency reports/chronologies and Professional Leads/experts (as required).

Ground rules will be agreed before the event to reinforce the educational spirit of the process, ensure opinions are respected and individuals are not 'blamed'. Accurate records of the event should be captured by a supporting facilitator.

The analysis and discussion during the review will be supported by having the following available;

- Policies and procedures – both multi-agency policy and individual agency policy/ procedures that are relevant to the review
- Chronology or agency reports completed by each organisation. These should contain all key events and highlight key areas of learning or good practice from each agency

This material should be circulated to all attendees before the learning event and the event should consider;

- What happened
- Why did it happen in this way
- Is it consistent with the agency policies/ procedures
- What are the areas of good practice
- Areas for improvement
- Lessons learnt
- What has already been changed or actioned as a result of this situation

After the learning event the person/s leading the review will need to consolidate all the information provided into an overview report and action plan that contains an analysis of key issues, lessons learned and recommendations.

A second event may take place to review how the agreed action plan has been implemented and learning disseminated in agencies.

A summary of the learning and associated action plans will be shared with CSAB by the Chair of the SAR.

Further information and guidance in relation to the SILP process can be found;
www.reviewconsulting.co.uk/about-silp/

2. Individual Management Reviews (IMR) – review and analysis of records

Individual Management Reviews (IMRs) are a way of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. The IMR should look openly and critically at individual and organisational practice and at the context in which the people were working to see whether the case indicates that improvements could be made. Individual organisational IMR reports can also identify good practice.

IMR authors should review case records for their agency and may also wish to discuss with staff their involvement with the adult and families/carers. Where staff are interviewed a written record of such interviews should be made and shared with the interviewee. The IMR author for each agency should not have been involved with the adult or family of be the line manager of practitioners involved. Individuals preparing reports should ensure that provision is made for care and support of staff involved within their agency. If the review finds that policies and/or procedures have not been followed, staff and managers should be interviewed in order to understand reasons for this.

IMR's should identify;

- Areas where practice could be strengthened;
- Organisational practice or procedures that impacted on the work undertaken;
- Missed communication opportunities;
- Examples of good practice;
- Recommendations for lessons learnt.

An overview report based on these key areas will then be drafted by the person leading the review and shared for agreement before submission to the SAR sub group. Family members or the individual concerned can contribute to this approach by providing their own chronology based on their understanding of support provided by organisations.

Templates and guidance will be provided for IMRs.

3. Peer Review

In the event of a peer review the SAR sub group will identify an individual from another Safeguarding Adults Board to review the multi-agency working in an identified case as part of an agreed reciprocal arrangement. In these cases the SAR sub group will agree and provide written terms of reference for review including timescales. The review will be shared with CSAB in the form of a written report provided by the identified individual.

4. Individual Agency Reviews

There are a number of reviewing processes undertaken around safeguarding cases within individual agencies represented on CSAB eg. Serious Untoward Incident (SUI) undertaken by NHS Trusts. It is appropriate and relevant for CSAB to have an overview of these. When an individual agency is conducting an investigation of this kind which involves a safeguarding issue the SAR sub group should be advised to assess if there is transferrable learning or if another level of review is required. The SAR sub group may also ask an agency to conduct a review into a particular case and forward a written report to the SAR sub group. The group will agree written terms of reference and a timescale for response. Written reports will be shared with CSAB.

5. Serious Case Review model

This is the traditional approach to undertaking reviews. Agencies involved are asked to submit both chronologies and IMRs. This information will provide the reviewer with a detailed analysis of each agency's work with the individual and an overview of multi-agency involvement. A Review Panel is established and with the person leading the review as Chair. The Panel usually comprises of senior managers from organisations involved. The person leading the review may also wish to have a representative from an advocacy organisation to ensure there is a level of challenge. The task of the review panel is to;

- Clarify through challenge the information provided in any IMRs
- Obtain an agreed overview of the multi-agency involvement with the adult
- Identify gaps in service provision
- Highlight missed opportunities to communicate
- Consider areas of organisational/individual practice that impacted on support provided
- Comment on good practice

The person leading the review is responsible for writing an overview report. This should be supported by an action plan and considered in draft by the Review Panel prior to the SAR sub group. Family members can be involved in the review process through regular consultation via a nominated person. Consideration should therefore be given to sharing findings of the review with family prior to publication.

Appendix 4
Parallel Review Process

In setting up a SAR consideration should be given to how the process can dovetail with any other relevant investigations which are running parallel. Agreement should be reached as to how SARs can be managed in parallel with other statutory reviews in an effective manner so that organisations and professionals can learn from the case. Establishing the relevant areas to be addressed at the outset can reduce potential duplication and distress for both family members and staff. Opportunities should be explored where reviews can be commissioned jointly so as to reduce duplication of work and resources for the organisations involved.

1. LeDeR

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period. A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. **http://www.bristol.ac.uk/sps/leder/about/**

2. NHS Serious Incident Investigations

Serious incidents in the NHS include abuse that resulted in (or was identified through) a Safeguarding Adults Review. The revised National Health Service England (NHSE) serious incident framework implemented from April 2015, explains the responsibilities and actions for dealing with serious incidents. It outlines the process and procedures to ensure that serious incidents are identified correctly investigated thoroughly and, most importantly learned from to prevent the likelihood of similar incidents happening again. It states that commissioners are accountable for the quality assuring the robustness of their providers' Serious Incident Investigations including the development and implementation of effective actions, by the provider to prevent recurrence of similar incidents.

See Serious Incident Framework: Supporting learning to prevent recurrence, NHS England (Updated: March 2015).

https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

3. Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide Review (DHR) or Serious Incident Review will be undertaken.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

4. MAPPA Serious Case Reviews

The guidance published in 2012 regarding MAPPA (Multi Agency Public Protection Arrangements) Reviews state that a review should be undertaken if a MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or any time in the 28 days before the offence was committed and the offence is murder, attempted murder, manslaughter, rape or attempted rape. Discretionary MAPPA SCRs can also be undertaken depending on the circumstances of a particular case and whether there has been a significant breach of the MAPPA guidance.

http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012- part1.pdf

5. Serious Case Reviews concerning Children.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of Local Safeguarding Children Board's (LSCB). This includes the requirement for LSCB's to undertake reviews of serious cases and advise on lessons to be learned in specified circumstances, namely where:

(a) abuse or neglect of a child is known or suspected and

(b) either;

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority their Board partners or other relevant persons have worked together'

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

The Working Together 2015 guidance clarifies the term "seriously harmed" as:

- A potentially life threatening injury;
- Serious and/or likely long term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

Cases which meet one of the criteria will always trigger a Serious Case Review. In situations where a child died by suspected suicide unless there is definitive evidence that there are no concerns about inter agency working the LSCB must commission an SCR. In addition, even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, police custody, on remand or following sentencing, in a Young Offenders Institution, or in a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 years was the subject of a deprivation or liberty order under the Mental Capacity Act 2005.

6. Criminal investigation/prosecution

Where a Safeguarding Adults Review is to take place and there are to be criminal proceedings, the Local Safeguarding Adults Board and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information. Further information can be found on the CPS website.

The framework deals with the process of a Safeguarding Adults Review and how it may affect the conduct of the criminal investigation/prosecution.

Appendix 5
SAR Review Group – Terms of Reference

This is intended as a guide, the agenda and terms of reference will vary depending on the methodology being applied for the SAR and will be agreed by the SAR sub group and CSAB Independent Chair.

Terms of Reference will vary depending on the agreed methodology for the review. Draft terms of reference should include the following;

- Timescales for completion of the review
- Methodology for completing the review (analysis of records)
- Recruitment/appointment of Chair/Facilitator (independent/partner organisation)
- Key issues to be explored (how agencies worked together; including timeline of significant events to be examined for chronologies and IMR's)
- Identify membership of the group to undertake review (referred to as Review Group) – option to co-opt members to present reports/findings which inform review
- Core tasks (examine decisions and actions taken, do they comply with policy and procedure; examine inter-agency working; facilitate learning events; seek contributions from family)
- Other reports/information to inform review; Coroners reports; Local Government Ombudsman reports
- Agree what documentation and outputs are expected at the end of the review; overview reports, executive summaries, lessons learned, action plans etc. Templates can be developed and provided for consistency.

The SAR Review Group will also consider any parallel review processes when establishing and agreeing the Terms of Reference and consider how these dovetail ensuring there are no unnecessary delays.