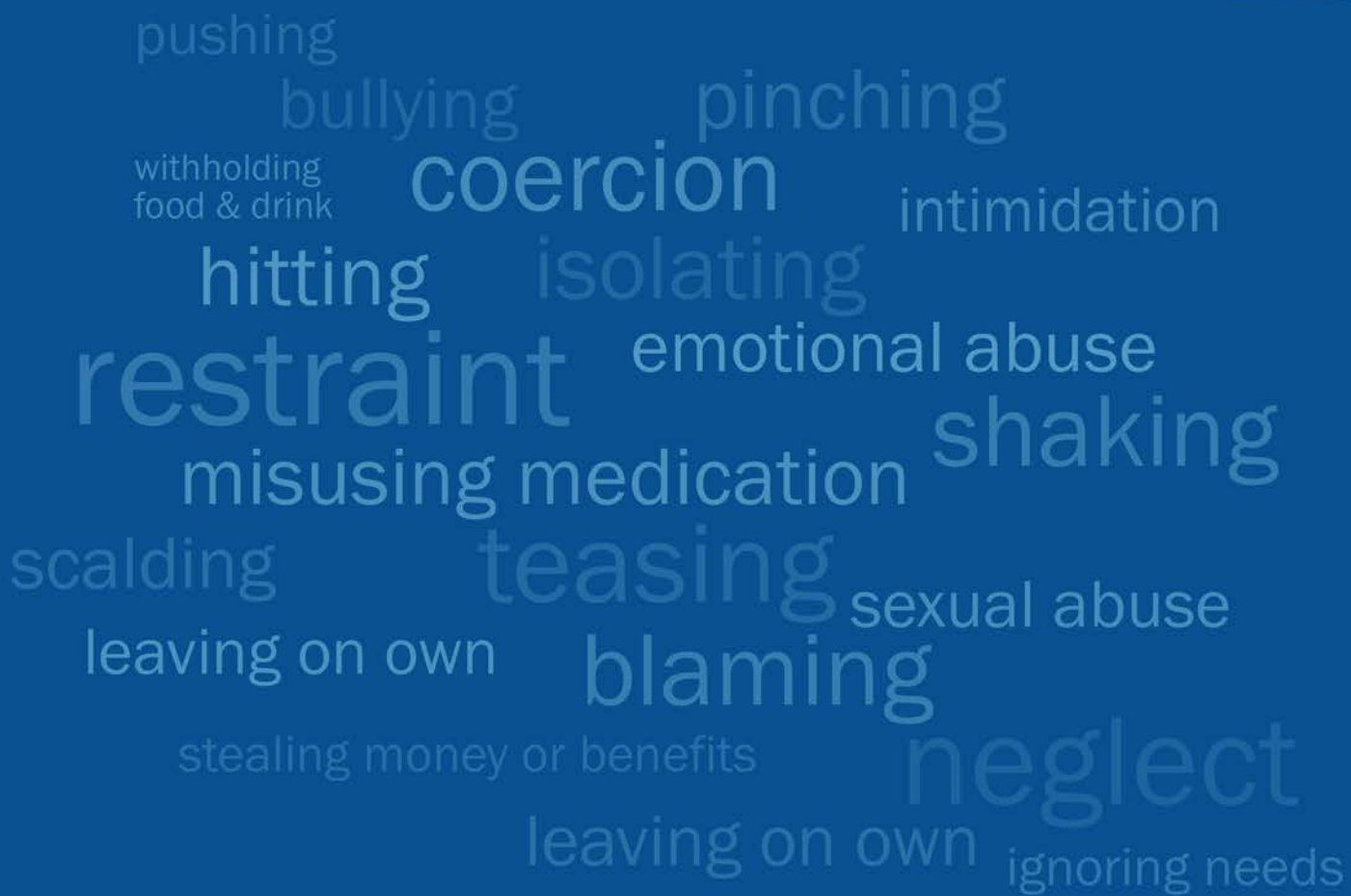
Solihull Safeguarding Adults Board
Protecting Adults Together

Safeguarding Adult Reviews (SARs)



Safeguarding Adults Reviews (SARs)

The Care Act 2014 introduces statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews), mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

1. Criteria

s44 of the Care Act 2015 - Safeguarding Adults Boards must arrange a SAR when:

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) Condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) The adult has died, and
(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) The adult is still alive, and
(b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

* Adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** Something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

2. Purpose

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The purpose of the reviews are not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

3. Principles

The following principles apply to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- The individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;

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

- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and

- Professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

3. SAR Methodologies

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases, the SAB will need to weigh up what type of 'review' process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The ultimate decision to arrange a SAR is the responsibility of the Chair of the SAB.

The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

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

3.1 Traditional Serious Case Review model

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

<u>This model includes</u>

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

<u>The benefits of this model are:</u>

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

The drawbacks of this model are:

- Methodology stems from children's arena so process to adults is not so familiar
- Resource intensive
- Costly
- Can sometimes be perceived as punitive and
- Does not always facilitate frontline practitioner input.

3.2 Action Learning Approach

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

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

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

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

The broad methodology is:

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

- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- Cost effective
- Enhances partnership working and collaborative problem solving
- Encompasses frontline staff involvement
- Learning takes place through the process enhancing learning.

The drawbacks of this model are:

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

3.3 Peer review approach

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

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

There are two main models for peer review:

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

The benefits of this model are:

- Increased learning and ownership if peers are from the SAB
- Objective, independent perspective
- Can be part of reciprocal arrangements across/between partnerships
- Cost effective

The drawbacks of this model are:

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

Duty of Candour

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

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

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

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

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

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

5. Resolving disagreements

It is acknowledged that there will be cases where vulnerable adults have moved from their 'home' area and may be placed and funded by an organisation that is outside the providers area. If that is the case, a SAR should be carried out by the Board that is responsible for the location where the serious incident took place. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the relevant Board Managers, with ultimate decision making and discussion being resolved by the Independent Chair of the Safeguarding Adult Board. Independent Chairs will agree on the mechanisms for presenting SARs that have cross border learning.

The SAR Checklist

Whichever model/approach used there are a number of key considerations.
This framework has been developed to help to decide the most effective and efficient way to identify learning for families, organisations and the Board.
Some of the elements below are mandatory and others are optional.

Terms of Reference
Mandatory

Essential

Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken.

Well formulated terms of reference are essential to ensure that the review is:

- Properly scoped
- Manageable
- Conducted by the appropriate people
- Within agreed timeframes.
  - To establish facts of the case
  - To analyse and evaluate the evidence
  - To risk assess
  - Make recommend

Ensure the review will answer "**THE WHY**" question.

Interface with other review processes
Mandatory

See appendix 1

Before starting a SAR identify if there is any links to other reviews and identify which takes priority. For example:

- DHR
- Children's SCR
- Serious Further Offence Review (Probation)
- Mental Health Review

In addition - Consider previous SAR's – will a recent SAR reinforce the same learning or is new learning to be identified?

Family & significant others involvement
Mandatory

Identify the degree to which victims/families will be involved in the review and how they will be informed of this review.

Victims/families (family members who have played a significant role in the life of the service user) should be notified that the review is taking place. Involvement can be:-

- Formal notification only
- Inviting them to share their views in writing or through a meeting.

The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.

Victims/families should be offered support.

Practitioner involvement
Mandatory

Practitioners will be involved in all SAR's – however the level of their involvement can be varied.

The following should be considered:

- Interviewing and taking a statement from practitioners for IMR's can result is staff having heightened anxiety.
- Practitioners must be offered support throughout a SAR.
- Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome.

Multi agency learning events that involve practitioners can:

- be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event.
- Assist practitioners to contextualize what happened and achieve closure.
- Result in quicker and more enhance learning.

Overview Report & Executive Summary
Mandatory

An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced.

An Executive Summary may also be commissioned.

All reviews of cases meeting the SAR criteria should result in a report which is published and readily available on the SABs website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to demonstrate openness, transparency and candour and to support national sharing of lessons. From the start of the SAR the fact that the report will be published should be taken into consideration. SAR reports should be written in such a way that publication will be likely to harm the welfare of any adult with care and support needs or children involved in the case.

Final SAR reports should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

Independent Author
Optional

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

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

An independent author must be:

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

They may also be independent of the SAB.

Experts
Optional

Consider if an expert is required to help to fully understand the situation and IMR findings.

If possible identify which expert will be needed or may be needed at the start of the process. However expert can be called upon at any time during the process.

Chronology
Optional

A chronology can provide a timeline – a sequence of events.

A clear chronology of events in a safeguarding case can show agencies where risks and can be used to cross reference significant events.

If using a chronology consider:

- The timeframe
- What you mean by key/significant events
- Using an agreed terminology avoiding abbreviations – for example Nurse A in one organisations chronology may not be the same Nurse A in another organisations chronology.

For complex cases it is recommended a chronolater tool is used.

References:

Care Act 2014

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

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

Warwickshire Safeguarding Adults Partnership – Safeguarding Adults Review (SAR) Protocol and Guidance

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

Shropshire and Telford & Wrekin Safeguarding Adults Board – Multi-Agency Procedure for Safeguarding Adults Reviews

Solihull Safeguarding Adults Board Local practice Guidance – Safeguarding Adults Reviews.

Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children March 2013

Review	Precedence
Domestic Homicide Reviews (DHR) Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	When the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that: the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by - (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Children's Serious Case Review (SCR) Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. For further guidance see – HM Government - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children 2013	When abuse or neglect is known - or suspected - and either: • A child dies • A child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child
Suicide Review	When a person who is in contact with mental health commits suicide, NHS boards undertake a suicide review to analyse what happened and recognise where anything can be done to make things safer for other people at risk.
Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review Criminal Justice and Court Services Act 2000 - strengthened by the provisions of the Criminal Justice Act 2003 (s325−327).	When the main purpose is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

Serious Further Offending Notification and Review Procedures Offender Rehabilitation Act 2014	Reviews will be required in any of the following cases:- Any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the NPS or a CRC; or whilst subject to ROTL. In addition, this will also apply during the 28 day period following conclusion of the management of the case; or Any eligible offender who has been charged with another offence on the SFO qualifying list committed during a period of management by the NPS or a CRC and is or has been assessed as high/very high risk of serious harm during the current sentence (NPS only) or has not received a formal assessment of risk during the current period of management; or Any eligible offender who has been charged with an offence, whether on the SFO list or another offence, committed during a period of community management by the NPS or a CRC, and the provider of probation services or NOMS has identified there are public interest reasons for a review. This may be due to significant media coverage Ministerial interest or where reputational risks to the organisation may arise; or If the offender has died and not been charged with an eligible offence but where the police state he/she was the main suspect in relation to the commission of a SFO.