Lambeth Safeguarding Adults Board

Safeguarding Adults Reviews (SAR)

POLICY AND PROCEDURE

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Acknowledgements to Croydon Adult Safeguarding Boards for allowing us to use their SAR policy and framework in the creation of this document.

Version Control

Version number	Purpose of the change or details of the change	Person making the change	Date
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1 02	Updates approved by SAR sub-group		16.03.20

Contents

1. Introduction

1.1 Section 44 of the Care Act 2014 and associated statutory guidance require all Safeguarding Adults Boards (SABs) to conduct Safeguarding Adults Reviews (SARs) (previously known as serious case reviews) in certain circumstances and permits SABs to arrange SARs in other circumstances. The Act requires Board member agencies to cooperate with and contribute to the carrying out of a SAR.

1.2 In the context of SARs, 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. SABs are free to arrange for a SAR or another type of practice review in any other situations involving an adult in its area with needs for care and support.

1.3 Lambeth Safeguarding Adults Board (LSAB) needs a locally agreed process for commissioning and learning from SARs. No single review model will be applicable for all cases: review methodology should be determined by the circumstances of each case.

"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."
Care and Support Statutory Guidance (DH: 2010) paragraph 14.135.

1.4 The purpose and underpinning principles of SARs, and the broad requirements and guidance for conducting SARs, are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

1.5 The Care Act statutory guidance (14.168) states that SARs should seek to determine what the relevant agencies and individuals involved in a case might have done differently that could prevented harm or death. This is so that lessons can be learning from the case and those lessons applied to future cases to prevent similar harm occurring again. SARs are reserved for situations where there is potential for extensive systemic learning due to serious questions about the multi-agency system as a whole.

1.6 The guidance (14.169) emphasises that 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 maintain maximum benefit. If individuals and organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

1.7 The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for the, 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.

1.8 This policy and procedure sets out how Lambeth Safeguarding Adults Board commissions, manages and governs SARS and includes:

- the process for referring a case for consideration for a SAR
- the criteria for when Lambeth SAB must or may commission a SAR;
- the processes for commissioning a SAR in Lambeth;
- how adults, families and staff will be supported and involved in SARs;
- how learning from Lambeth SARs and from other SARs nationally will be acted on in Lambeth; and
- templates for letters, terms of reference and reports.

2. Criteria for a Safeguarding Adults Reviews

2.1 A Safeguarding Adults Board is the only body that can commission a Safeguarding Adults Review. As set out in S44 of the Care Act 2014, a SAR must take place when:

- an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- adult has experienced serious abuse or neglect, but has not died

2.2 "Serious abuse or neglect" may include:

- the individual would have been likely to have died but for an intervention,
- the individual suffered permanent harm as a result of abuse or neglect,
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect;
- the individual has sustained a potentially life-threatening injury through abuse or neglect,
- the individual has suffered serious sexual abuse.

This is not an exhaustive list. The final decision rests with the LSAB and the Independent Chair as to whether abuse/ neglect was serious enough to warrant a SAR.

2.3 For most cases, a Section 42 safeguarding adults' enquiry will have been completed before it is referred for consideration for a SAR. Where the safeguarding concern raises questions about the local authority's response, Lambeth will carry out a Management Review (which will take the shape of a S42 enquiry however be completed by a Manager).

2.5 In some cases, where there is not appropriate to commission a SAR but where there is clear potential to identify sufficient and valuable learning to improve how organisations work together to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future, the SARSG may direct for a learning review or case file audit to be undertaken by an internal facilitator independent to the case. An example of this could be a serious incident that does not meet the criteria for a SAR but that the LSAB wants to review. The SAR sub-group will keep a log of these cases and the agency tasked with overseeing any identified actions.

2.6 There may also be other situations where the LSAB may arrange for a SAR to be undertaken. This could include:

- A case featuring repetitive or new concerns or issues which LSAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

3. Requesting a Safeguarding Adults Review

3.1 **Any agency, professional or individual** can bring a case to the attention of the LSAB and request a SAR if they believe it to fit the criteria listed in section 2. **Requests for a SAR** (except for those referred by the Local Authority via the safeguarding enquiry process) **must be made in writing** using the SAR request form (see Appendix one)

3.2 A case may come to notice due to (for example but not limited to): an individual worker/ volunteer notifying a manager; a serious incident or accident report; a complaint or whistle-blower; a Section 42 safeguarding enquiry; notification from the Care Quality Commission (CQC) or via 'Need to Know' Form.

3.3 To ensure the efficient identification of appropriate cases for SAR consideration, relevant operational managers in agencies need to be aware of the criteria for a SAR. A referral to the SAR subgroup should not be used an escalation process or to defer what should more appropriately be dealt with through an adult safeguarding enquiry process.

3.4 The person's family should be informed of the concerns and that a Safeguarding Adults Review referral is planned so they have an opportunity to give their view about the referral and discuss how they might want to be involved.

3.5There may also be parallel processes in place such as an NHS Serious Incident investigation, criminal investigation or Coroner's Inquest. Whilst these should not prevent a referral being made, the SARSG will need to consider the timing and management of any subsequent multi-agency review.

4. Role of the Safeguarding Adults Review sub-group

4.1 A log of potential SARs will be created and presented at the SAR sub-group. The SAR sub-group will consider the information provided and submit a recommendation to the Chair of the LSAB as to whether the criteria for a SAR (see Section 2) has been met and, if so, to recommend which SAR methodology should be used.

4.2 Any disagreements between SARSG members, will be discussed between the SARSG and LSAB Chairs in order to reach a resolution.

4.3 Some cases referred to the SAR sub-group may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review, Learning Disability Mortality Review (LeDeR) or a children's serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

4.4 Some cases referred to the SAR sub-group may involve one or more local authorities or other statutory organisations. In such cases, the SAR sub-group Chair will notify the Chair of the LSAB who will then contact the Chair of the relevant Local Safeguarding Adults Board to discuss next steps.

4.4.1 If following the above, the LA/ organisation is in disagreement that a SAR should be undertaken; the Chair of the LSAB will contact that LA/ organisation and SAB for further discussion.

4.5 **If a request for a SAR is upheld**, the SAR sub-group will determine who needs to be notified including:

- the person requesting the SAR and relevant statutory director(s) to inform them of the outcome of the SAR request and reasons for the decision.
- chief executives (or equivalent) of all relevant agencies (copied to their respective Board member)
- relevant commissioning and regulatory bodies
- Notification points as advised by particular organisations e.g. police and SLaM.

4.6 **If a request for a SAR is turned down**, a notification will be sent to referrers to advise them of the reasons for this. Where the requestor is dissatisfied with this outcome, they should notify the Chair of LSAB in writing, who will discuss and review (if necessary) the decision with the requestor.

5. Deciding on SAR Methodologies:

5.1 One key goal of the SAR Subgroup should be to weigh up what type of 'review' process will promote effective learning and improvement action. Each methodology is valid in itself and no approach should be seen as more serious or holding more importance or value than another. The methodology selected must offer the most effective learning and involvement of key staff/ family weighed against the cost, resources and length of time required to conduct the review.

5.2 The following should be considered in selecting a SAR methodology:

- Is the case complex, involving multiple abuse types and/ or victims?

- Is significant public interest in the review anticipated?
- Is large-scale staff/ family involvement wanted/ appropriate?
- Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained lead reviewers available in-house or nationally for the method selected? Are resources available to train or commission a lead reviewer?
- Can value for money be demonstrated?
- Which agencies should be approached to contribute to funding the SAR?

5.3 In addition to selecting a SAR methodology, the sub-group must also decide:

- Level of independence from the case required of SAR subgroup members (it is advisable that members have not had involvement in the case nor line management responsibility for staff writing a report for the SAR).
- Whether agencies are required to secure their files/ records.
- The Terms of Reference for the SAR (see appendix 5) including timescales for completion and how learning from the SAR will be disseminated and embedded (see section 11).
- The required output from the SAR (e.g. a report).
- Whether an independent author is required, and level of independence.

5.2 Where the group believes a review is not within the scope of SAB, it can make recommendations to other organisation(s) that a review is conducted under alternative mechanisms.

6. List of SAR Methodologies

6.1 Appendix 4 outlines the key features and advantages and disadvantages of selected methodologies, including:

- Traditional approach
- Systemic approach - Learning Together
- Significant Incident Learning Process (SILP)
- Significant Event Analysis
- Appreciative enquiry
- Peer Review

This is not an exhaustive list and SAR sub-group members should consider flexible approaches to methodology, so as not to be too prescriptive. These proposed methodologies should be viewed with the considerations outlines in section 5 in mind.

6.2 The SAR Sub-group may choose to recommend a combined approach.

7. Commissioning a Safeguarding Adults Review

7.1 'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' (March 2013) states:

"Cost effectiveness is an issue for Safeguarding Adults Boards as an independent commission can prove expensive and in some areas there is an all-or-nothing approach to commissioning reviews. Some Boards, and very recently all the London authorities, have developed a proportionate approach which offers Boards a range of options to match against the seriousness and circumstances of the case, allowing a faster and more cost-effective response while maximising the Board's learning."

7.2 The LSAB agrees that there are a number of local expertise which would be appropriate, in some cases, to carry out a Peer Review methodology. This would be acceptable where the peer reviewer's own organisation is entirely independent of the safeguarding concern.

7.2 When commissioning an independent reviewer to undertake a SAR, consideration should be given to an individual's experience and expertise in this area, which may include seeking testimonials from previous commissioners/Boards. There should always be flexibility to select an independent reviewer without the necessity of a lengthy selection process.

7.2.1 The reviewer will give assurance that they understand the requirements of the General Data Protection Regulations and how it impacts on the retention of any information stored by them connected to the SAR.

7.2.2 The Reviewer should be familiar with the requirements of the National SAR Library (RiPfA and SCIE) including SAR Quality Markers and agree to categorise the learning as outlined by the guidance issued by them. They will also assist the SAR sub-group with the completion of supporting learning documentation which is to be forwarded to the SAR Library.

8. Adult/Family Involvement and Independent Advocacy

8.1 This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures, and Section 68 of the Care Act and associated statutory guidance.

8.2 Adults and/ or families should be invited and supported to contribute to SARs if they wish to do so, in order that an inclusive approach is taken and that their wishes, feelings and needs are placed at the heart of the review.

8.3 The SAR lead reviewer will make contact with the adult(s), their family and/ or representatives early on to establish:

- Why and how a SAR will be undertaken into their (family member's) case.

- How they would like to be involved – e.g. views contributed via telephone conversation, or interview, or attendance at SAR meetings.
- Any support or adjustments they would need to facilitate their involvement.
- Their initial views, wishes, concerns, and any answers/ outcomes they would like to achieve from the SAR

9. Staff Involvement

9.1 This section must be read in conjunction with Section 2 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

9.2 As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers and their line managers. It should be made clear that the review process can be lengthy.

9.3 It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/ or family. All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so that real learning and improvement can happen.

9.4 Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offered support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

10. Professional Conduct Issues arising

10.1 This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

10.2 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR sub-group to deal with these.

10.3 Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR sub-group chair. It then remains the responsibility of the individual agency to follow up on the concerns passed on by the SAR subgroup, in line with their own policies and procedures

11. SAR Reports

11.1 This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

11.2 The required output of a SAR – e.g. whether a report is needed, and/or independent authorship will be dependent on the methodology used. It is anticipated that in all statutory SARs a report will be required.

11.3 SAR reports should provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence. The report should be written in plain English and contain findings of practical value to organisations and professionals. A template SAR report is provided at Appendix 7.

11.4 The SAR sub-group should receive and agree the draft report before it is presented to the LSAB so that individuals are satisfied that there is sufficient analysis, scrutiny and evaluation of evidence.

11.5 The adult(s) and/ or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process.

11.6 Any recommendations made in the report must be SMART and CLEAR (Buckley and O'Nolan 2014).

S – Specific; immediately understandable **M –** Measurable; will make a difference **A –** Accessible; considering resources and capacity **R –** Relevant and realistic; drawn from evidence **T –** Timely	**C –** the case for change **L –** Learning orientated **E –** Evidence based (current context and research) **A –** Assign responsibility **R –** Review (desired outcomes and resources required)

11.7 In line with Schedule 2 of the Care Act, Lambeth SAB will include findings from any SAR (and information about any ongoing SARs) in its Annual Report along with the actions it has taken, or intends to take, in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report.

11.8 All documentation the SAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

11.0 Lambeth SAB will decide to whom the SAR report, in whole or in part, should be made available and the means by which this will be done. This should include publication via the Lambeth SAB website and the SCIE Safeguarding Adults Review Library. Considerations of reputational risk or national learning arising from the case may affect decisions to publish. **Any reports to be published must be fully anonymised.**

12. Acting on the recommendations of the SAR

12.1 The SAR sub-group will translate learning and recommendations from the SAR report into a proposed multi-agency action plan if required.

12.2 The multi-agency action plan will indicate:

i. The actions that are needed.
ii. Responsibilities for specific actions.
iii. Timescales for completion of actions.
iv. The intended outcomes: what will change as a result?
v. Mechanisms for monitoring and reviewing intended improvements.
vi. The processes for dissemination of the SAR report or its key findings.

12.3 The action plan will be presented to the LSAB as it will need to be endorsed at senior level by each organisation to whom it relates. The LSAB may decide not to implement a recommendation but must state the reason for that decision in its Annual Report.

12.5 Individual agencies may also be asked by the LSAB to produce their own internal action plans if required. This may include recommendations to national bodies.

12.6 Board members of the LSAB are responsible for ensuring all actions for which their organisation is responsible are completed, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. Wherever possible, agencies should make every effort to capture learning points and take internal improvement action while the SAR is in progress, rather than waiting for the SAR report and action plan.
12.7 The LSAB will monitor progress on all recommendations (or delegate to an appropriate sub-group) and may request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

12.8 The LSAB will also ensure that key learning is disseminated to all staff and volunteers working in Lambeth, in order to drive forward improvements and ensure learning is embedded. This may be done via:

- Multi-agency learning-events or workshops.
- Multi-agency briefings / newsletters.
- Bitesize learning material learning to facilitate discussions amongst teams and services.
- Publication of SAR final reports on LSAB website for a minimum of 12 months and thereafter to be made available upon request
- Publication on SCIE SAR Library

12.9 The SARSG will be responsible for enabling effective methods of dissemination and measuring how the learning is applied in practice and makes a difference.

13. Communication and media

13.1 The SAR Sub-group must ensure that there is a cohesive approach and response to media enquiries resulting from a Safeguarding Adult Review and that the LSAB and individual agency leads act in consultation.

13.2 It will generally be the case that where there is an ongoing criminal investigation the police will be the lead agency and otherwise it will be the most appropriate agreed agency, usually the Local Authority.

13.3 Prior to publication of a SAR, any publication arrangements and media strategy will be agreed by the SAR Subgroup (if relevant), the LSAB Independent Chair and the relevant Local Authority lead member. If required, the Independent Chair together with the lead member will normally act as the spokesperson on behalf of the LSAB (please see Appendix 8 for further information on process).

13. Further Reading

Lambeth Safeguarding Adults Board
https://www.lambethsab.org.uk/

Safeguarding Adults Review under the Care Act: implementation support (SCIE)
http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/files/safeguarding-adults-reviews-under-the-care-act-implementation-support.pdf

Sharing Information
http://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/

User involvement in Safeguarding
http://www.scie.org.uk/publications/reports/report47/

Care and Support Statutory Guidance
https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016

E-learning Resources

Safeguarding Adults under the Care Act
http://www.scie.org.uk/publications/elearning/adultsafeguarding/

Mental Capacity Act
http://www.scie.org.uk/mca/e-learning/

All appendices mentioned in this document can be found on the LSAB website.