Redbridge Safeguarding Adults

REDBRIDGE SAFEGUARDING ADULTS BOARD (RSAB)

Safeguarding Adults Review (SAR) Protocol

3rd Edition

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1. Introduction

1.1 This document, now in its 3rd Edition, is the agreed Protocol for undertaking Safeguarding Adult Reviews (SARs) within the Redbridge Safeguarding Adult Board (RSAB) partnership.

1.2 The original document was developed following the Association of Directors of Adult Social Services (ADASS) issue of a National Framework of Standards, in 2005, for good practice and outcomes for adult protection that included the recommendation that each Safeguarding Adult Board should have in place a SAR Protocol

1.3 This Protocol sets out the policy and procedure for commissioning and undertaking a SAR relating to the death or serious incident involving an adult(s) at risk of abuse or neglect living in Redbridge. It will also assist professionals in deciding whether to refer a case for consideration as a SAR and provides the relevant templates used during Reviews.

2. Background

2.1 The Care Act 2014 placed a statutory duty on Safeguarding Adults Boards to undertake SARs and a requirement on Board member agencies to cooperate with, provide information for, and contribute to the carrying out of a Review.

2.2 The Act confirmed the standards developed by ADASS and required that SARs are informed by the six principles of adult safeguarding:

- **Empowerment** – personalisation and the presumption of person-led decisions and informed consent.
- **Prevention** – it is better to take action before harm occurs.
- **Proportionality** – proportionate and 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 of play in preventing, detecting and reporting neglect and above.
- **Accountability** – accountability and transparency in delivering safeguarding.

2.3 The Care and Support Statutory Guidance, updated in July 2018, Chapter 14, provides specific guidance on SARs (see section 14.162 – 14.173) and this is supported by additional information and guidance provided by the Social Care Institute for Excellence (SCIE) in 2015, including the SARs Library, established in 2018.

3. The Care Act and Safeguarding Adults Reviews (SARs)

3.1 The introduction of the Care Act 2014 placed safeguarding adults and Safeguarding Adults Boards (SABs) on a statutory footing. It also detailed the requirement on SABs to undertake Safeguarding Adults Reviews (Part 1, Section 44) (see below).

(1) A 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 others 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) A 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).
(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

4. Purpose of a Safeguarding Adults Review (SAR)

4.1 The purpose of holding a Safeguarding Adult Review (SAR) is not to reinvestigate or apportion blame but to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard adults, including an understanding of what could have been done differently;
- review effectiveness of procedures;
- inform and improve local inter-agency practice;
- improve practice by acting on learning; and
- highlight and share good practice in relation to safeguarding adults.

4.2 SARs are not disciplinary proceedings and should be conducted in a manner which facilitates learning and appropriate arrangements must be made to support staff

involved with the case. If there are issues of performance and/or discipline which needs to be addressed arising from the SAR then these must be dealt with within each agency's normal procedures.

4.3 Additionally, SARs are not enquiries into why an adult has died (or been significantly injured), or to decide who, if anyone, is culpable. These are matters for criminal courts and coroner's courts.

5. Criteria for a Safeguarding Adults Review (SAR)

5.1 RSAB, on behalf of its partner agencies, has a responsibility for commissioning a SAR when there are concerns about the way inter-agency working to safeguard an adult at risk may have been a factor in:

- The death of an adult at risk (including suicide) where abuse or neglect is known or suspected to be a factor in their death.
- A potentially life threatening injury being sustained by an adult at risk through abuse or neglect.
- Sexual abuse of a serious nature of an adult at risk.
- Significant or permanent harm to an adult at risk through abuse or neglect
- Significant abuse which has taken place in an institution, or where multiple persons causing harm or persons being harmed are involved. Such reviews are, likely to be more complex, on a larger scale and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant.

5.2 Where a decision needs to be made whether or not a case should be the subject of a SAR in circumstances other than when an adult at risk dies – a 'yes' answer to several of these questions is likely to indicate that a review will yield useful lessons:

- Was there clear evidence of risk or significant harm, which was not recognised by agencies in contact with the adult at risk or perpetrator, or not shared with others or not acted upon appropriately?
- Did the abuse occur in an institutional setting?
- Does one or more agency feel that its concerns were not taken seriously or acted upon by another?
- Does the case indicate that there are failings in the formal protection procedures that go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the RSAB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated or acted upon?

6. Making a referral for a Safeguarding Adult Review (SAR)

6.1 SABs are the only body that can undertake a SAR. However, any agency or professional may refer a case believed to meet the criteria. In most circumstances, a discussion with the relevant safeguarding lead about the concerns, prior to making a referral, is usually helpful. The referral should be made in writing to the Chair of RSAB, including a brief summary of the case and identification of all the factors that suggest that the criteria for a SAR has been met.

6.2 It may also be necessary to consider whether the case meets the criteria for other multi-agency reviews. For example:

- Serious Case Review (SCR)
- Domestic Homicide Review (DHR)
- MAPPA Serious Case Review
- Mental Health Homicide Review (MHHR)
- Serious Incident (SI)

6.3 The Chair of the RSAB is ultimately responsible for deciding whether to undertake a Review or not. The decision will usually be taken in consultation with the Board and /or partner agencies. The Chair can also seek the option of a peer challenge from another SAB Chair to support the decision-making process.

6.4 If the Chair's decision is that a SAR is not appropriate, there may still be valuable learning from the case to be explored. This may be through, an Internal Learning Review, including an Individual Practice Review (IPR) undertaking by a single agency or a Near Miss Review (NMR) which is a quick review and helpful way of understanding what nearly went wrong. Another possibility is a Case File Audit. These will normally be facilitated by a nominated member of the SAB, independent of the case or any of the specific agencies involved.

7. Procedure for undertaking a SAR

7.1 Once the Chair has made a decision on the referral for a SAR, the RSAB Business Manager is responsible for advising the referring individual or agency in writing.

7.2 If it is agreed to undertake a SAR, the Board, or the RSAB Chair in consultation with partners if the matter needs to be progressed without waiting for a Board meeting, will establish a multi-agency SAR Panel. The Panel will be chaired by the Independent Chair of the RSAB. Other members will include:

- senior representatives from the organisations and agencies involved in the case under review;
- Care Quality Commission (CQC), where appropriate;
- Care Commissioning Group (CCG) Adult Safeguarding Lead;
- Police, where appropriate and where it would not conflict with any ongoing criminal investigation;
- a legal representative from the Local Authority, as necessary;
- the Local Authority's Head of Safeguarding and Adult Protection;
- the SAB Business Manager; and
- a Lead Reviewer who is independent of the case and the organisations/agencies involved, if the Panel decides to appoint one.

7.3 The above will form the core membership of the Panel. The Panel will meet with whatever frequency is required to ensure that the review is completed to a high standard, and without unnecessary delay. Additional members may be co-opted to address particular case issues. Nominees will have appropriate levels of experience of safeguarding and hold a senior role in their agency. .

7.4 The SAR Panel is responsible for determining the Terms of Reference (ToR) for the review, and for setting timescales for completion of management reviews and reports.

7.5 Where there are criminal proceedings in connection with the case, the Panel must decide in consultation with the relevant criminal justice agencies whether the Review should start or be completed until after Coroners or criminal proceedings have concluded.

7.6 The ToR should address the following points as a minimum:

- Identification of SAR Panel member agencies.
- What appear to be the most important issues, or key lines of enquiry (KLOE), to consider in order ensuring learning from the case?
- How can the relevant information best be obtained and analysed, including any necessity to request relevant individuals to give a direct account?
- Over what time span should case details and chronology of intervention be reviewed?
- What information from family, or service, history will assist the SAR Panel?
- Which agencies or individuals should contribute to the Review, and is there a need for other written information to be obtained from other sources?
- Should the vulnerable adult, their family, or informal carers be invited to contribute to the review? If so, which is the most appropriate method to enable their participation?
- How should the review process take account of a Coroner's inquiry, or any criminal investigation?
- The time line for the Review and presentation to the RSAB.

7.7 The SAR Panel is responsible for agreeing the methodology for undertaking the Review. This may or may not include the appointment of an independent reviewer, depending on the methodology chosen.

7.8 SARs can be conducted in a variety of ways. The traditional method involves analysis of the involvement of agencies, led by an independent Lead Reviewer. With this method individual agencies are asked to review the practice within their organisation through Individual Management Reviews (IMRs) and Chronologies which then form part of an Overview Report. Other methods include action learning, peer review, significant event analysis or development of a multi-agency combined chronology. Methods can be combined.

7.9 Each relevant service should undertake a separate IMR of its involvement in the case as soon as possible. Relevant independent professionals including G.P's should contribute reports of their involvement. A designated professional should review and evaluate the practice of all health professionals and providers within a Clinical Commissioning Group (CCG) area. This may involve reviewing the involvement of individual practitioners and Health Trusts and advising on confidentiality and disclosure issues.

7.10 Those conducting management reviews of individual agencies, or producing the overview report, should not have been directly concerned with the adult at risk or family, or the immediate line manager of the practitioner(s) involved.

7.11 IMRs should be completed using the template provided by the RSAB Business Manager and should include:

- A comprehensive chronology of involvement by the agency and professionals in contact with the adult at risk, during the period set out in the agreed Terms of Reference.
- A brief summary of decisions reached, services offered and provided and other action taken.
- Analysis of involvement which includes consideration of events that occurred, decisions made and actions taken or not. Where judgements were made or actions taken, which indicate that practice or management could be improved, try to get an understanding not only what happened but why.

Consider explicitly:

- Were practitioners sensitive to needs of the adult at risk, knowledgeable about potential indicators of abuse or neglect, and about what to do if they have concerns?
- Were effective policies were in place for safeguarding adults at risk?
- What were the key relevant points/opportunities for assessment and decision-making? Do assessments and decisions appear to have been reached in an informed and professional way? Did actions accord with assessments and decisions made i.e. were appropriate services offered/provided or relevant enquiries made?
- What information was obtained about the adults at risk wishes and how was this recorded?
- Was practice sensitive in terms of race, culture, language and religious identity?
- Were senior managers, or other agencies or professionals involved at points they should have been?
- Was the work consistent with the policy for safeguarding adults at risk and wider professional standards?
- What do we learn from this case?
- Are there lessons about the way this agency safeguards adults at risk?
- Is there good practice to highlight as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency) management and supervision, working in partnership with other agencies or resources?

Recommendations for action should include addressing the following:

- What action should be taken by whom and when?
- What outcomes should these actions bring about, and how will the agency review whether they have been achieved?

7.12 The Independent Chair of the RSAB and the Business Manager will be responsible for ensuring administrative arrangements are completed and that the Review process is conducted according to this Protocol.

7.13 Resources are needed for undertaking and supporting a SAR. The statutory partners on RSAB should agree any shared funding required.

7.14 The Panel will consider all material produced for the review, including individual management reviews, any independent reviewer's report, and reports of any other review processes as referred to in 7.8 above. The Panel is responsible for agreeing an overview report to be presented to the Safeguarding Adults Board, summarising the findings of the review, the learning identified, and recommendations to translate that learning into practice.

7.15 The process from the first meeting of the SAR Panel to completion of the overview report to the RSAB should be targeted to be complete within six months.

7.16 From the Overview Report, a SAR Action Plan will be developed which includes any resulting actions, the responsible agency, timescale, intended outcomes and the mechanism for monitoring and reviewing intended improvements in practice.