13 Safeguarding Adult Reviews

13.1 Introduction

Section 44 of the Care Act 2014 requires Local Safeguarding Adult's Boards to arrange a Safeguarding Adult Review (SAR) when an adult, with needs for care and support who lives in its area, 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 person at risk.

A SAR can also be conducted when a person has not died but it is known or suspected that they have experienced serious abuse/neglect, sustained potentially life-threatening injury, serious sexual abuse or serious/permanent impairment of health or development and there is cause for concern about the way agencies have worked together.

The Safeguarding Adults Board can also commission a SAR when the partnership is in agreement that a case provides an opportunity to learn from good practice that could be applied to agencies working with adults.

All agencies represented on the Rochdale Borough Safeguarding Adults Board have a duty to contribute in undertaking the review, sharing information and applying the lessons learnt.

The purpose of an SAR is to seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. The SAR brings together and analyses the findings from individual agencies involved, in order to make recommendations for future practice where this is necessary. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. It is a review of multi-agency working not an investigation of an individual's actions and its purpose is to identify learning, 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 Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.

The individual (where able) and their families should be invited to contribute to the SAR and there should be early discussions to agree how they will be involved and how their expectations will be managed appropriately and sensitively. The adult or their family must be informed of any decision not to have early engagement with them together with the reasons for the delay. Review outcomes will be shared appropriately with the family and others affected by the SAR.

Six principles, which are specified in the Care Act 2014, underpin the work of the RBSAB:

Empowerment
People being supported and encouraged to make their own decisions and informed consent.

> *I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.*

Prevention
It is better to take action before harm occurs.

> *I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.*

Proportionality
The least intrusive response appropriate to the risk presented.

> *I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.*

Protection
Support and representation for those in greatest need.

> *I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.*

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

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

Accountability
Accountability and transparency in delivering safeguarding.

> *I understand the role of everyone involved in my life and so do they.*

SARs must be trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them, if individuals and organisations are to be able to learn lessons from the past. The following values will be applied by the RBSAB and partner organisations to all reviews:

- there will 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 the promotion of good practice; the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- 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;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- 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. Please see the leaflet "Safeguarding Adult Reviews – Information for families" which is available on the RBSAB website https://www.rbsab.org/professionals/safeguarding-adult-reviews/

When the SAR is relating to an individual who lives out of the borough, communications will need to take place between the host authority and the authority where the individual resides as to who will lead on the SAR.

13.2 Criteria

The Care Act 2014 states that the Safeguarding Adults Board is the only body that can commission a SAR and it must arrange a SAR of a case of an adult in its area if:

- *The case involves an adult with care and support needs (whether or not the Local Authority was meeting those needs)*
- *There is reasonable cause for concern about how the Safeguarding Adult Board, its members or organisations worked together to safeguard the adult*

AND

- *The person died (including death by suicide) and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)*

OR

- *The person is still alive but the Safeguarding Adults Board knows or suspects they have experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.*
- *This may be 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.*

The Care Act Statutory guidance states that SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. Locally, this would be where it would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which

may not meet criteria for a SAR. This might be innovative or particularly good examples of practice. In these cases, the RBSAB would commission a discretionary SAR.

13.3 Referring for a Safeguarding Adult Review

Any agency or professional body, elected members, MPs or a Coroner may refer cases to RBSAB for consideration of a SAR.

If the individual is still alive, the referring agency must inform the individual of the SAR referral so that they are informed that their information will be shared as part of this statutory process.

Cases should be referred to the RBSAB in a timely way, usually within 1 month of a person's death/significant event so not to delay any other processes that may be ongoing. The RBSAB does acknowledge however that there may be exceptional circumstances to this. Referrers will be expected to provide an explanation if referrals are delayed.

Should any family member or other individual feel that a person should be considered for a Safeguarding Adult Review, this should be raised with the relevant agency who will then make the decision as to whether to submit a Safeguarding Adult Review referral. The agency should inform the family member or another individual if a SAR referral is made.

Before submitting a referral to the Board's Business Unit for screening, individual organisations should ensure the referral is appropriate and meets the specified criteria by consulting with their agency strategic safeguarding lead. Referrals must be sent in by using the RBSAB Referral Form (Appendix 2). SAR Referrals should be submitted to rbsb.admin@rochdale.gov.uk . All referrals should be submitted securely as they contain personal details. This is in line with the RBSAB Information Sharing Protocol. Likewise, all data in respect of a SAR should be kept securely.

13.4 Screening of referrals for Safeguarding Adults Review

The process for notification and screening for SAR is:

Following the receipt of a referral, the Independent Chair of RBSAB, Head of Safeguarding and Practice Assurance and RBSAB Business Manager will confirm agreement to progress to SAR screening within 5 working days. There may be instances where the referral submitted is inappropriate and in these cases, the referrer will be contacted to agree the most appropriate course of action.

If the referrer does not agree with the decision made by the Business Unit to either progress or not progress to SAR screening, the referrer can challenge this. The Safeguarding Adult Review Sub-Group has oversight of all cases and activity in relation to Safeguarding Adult Reviews and therefore disputes as to thresholds will be looked at through this forum.

The Business Unit will inform Board members when a referral is progressed to SAR screening. The Business Unit will request information from partner agencies to be submitted within 10 working days.

A screening meeting will be held and the panel will make a recommendation to the Chair of RBSAB as to the need for a review (or not) and recommend an appropriate learning model to be used if required.

Membership:

- Safeguarding Board Business Manager (Chair)
- Head of Safeguarding (Vice Chair)
- Agency representatives on case by case basis

Within 5 days of the screening meeting, the Chair of the RBSAB will consider the case and forward the decision to the Business Unit. The Business Unit will then inform RBSAB members.

13.5 Family contact and involvement

It is important that all family members, where possible, are approached to inform them about the decision to undertake a SAR, and to give them an opportunity to contribute. Depending on the level of contact they have had with the person who is the subject of the SAR, they may have a unique perspective about how services did or did not provide an effective intervention, which could be invaluable when conducting the SAR.

The SAB must always be sensitive about the timing of any contact, particularly if the SAR is focusing on the circumstances leading up to a person's death that is relatively recent and the family are still grieving.

Contact with the family would usually commence as soon as possible after the decision to carry out a SAR has been made. When contact with family is agreed with the panel, it is the responsibility of the chair/author of the SAR to initiate contact, and discuss with the family the level of involvement they would like to have. It may be appropriate to do this via an advocate that the family are familiar with and trust. Family members should be given the opportunity to understand and influence the scope of the review, including the Terms of Reference and should be allowed to have first-hand contribution to the review.

Family member should be updated regularly if they want this and the timescale for updates should be agreed with them, including sharing the draft timetable for completion.

Contact will usually cease when the SAR report and improvement plan has been published. However families may wish to maintain contact after the report has been published in order to give them the opportunity to be assured that actions in the improvement plans have been carried out.

13.6 Alternatives to conducting a Safeguarding Adult Review

There may be circumstances in which there is a need to look at some issues without conducting a full Safeguarding Adult Review. In these circumstances the Board may recommend to the Chair of the Board that:

- Individual agencies should conduct an internal review, or
- The Board carry out a limited form of review focusing on specific issues (a case audit)

There are a number of reviewing processes undertaken around safeguarding cases within individual agencies represented on the Safeguarding Adults Board. An example would be the Serious Untoward Incident process undertaken by NHS Trusts and it is appropriate for the RBSAB to have an overview of these. When an individual agency is conducting an investigation of this kind which involves a safeguarding issue, the SAR Screening sub-group should be advised of this to enable them to assess whether there may be transferable learning, or whether another level of review is needed.

13.7 SAR Methodology

The SAR Screening sub-group will give consideration to the most appropriate methodology to use when making a recommendation to the Chair, as no one model will be appropriate for all cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however it will be determined by and proportionate to the specific circumstances and the scale of the situation. There is flexibility in determining the precise process, including variations and combinations of methodology elements on a case by case basis. However reviews will generally have three elements:

- Information gathering
- Learning event
- Analysis and reporting

In all circumstances the review process should take no more than 6 months. Any SAR will need to take account of a coroner‘s inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication

Possible methodologies for Safeguarding Adults Reviews are set out in Appendix 1. This list is not exhaustive and the SAR Screening sub-group will use its collective experience and knowledge to recommend the most appropriate learning method for the case under consideration. Each method of Review is valid in itself and no

approach should be seen as more serious or holding more importance or value than another. All Safeguarding Adults Reviews conducted on behalf of the Board are of equitable significance and value.

The RBSAB will endeavour to ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also engage, where appropriate, with the adult and/or their family.

It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership 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;
- an ability to promote an open, reflective learning culture.

Those undertaking a SAR will be formally commissioned and expectations will be agreed with the Business Unit including fees and timeframe for the review. A single point of contact will be provided for the Business Unit.

All of those participating in a Safeguarding Adult Review will be provided with guidance to support them in carrying out that role. Regardless of which methodology is used, contributing agencies need to be mindful that there may be public scrutiny of information provided by agencies to the Safeguarding Adult Review and, in particular, HM Coroner may request information. All agencies should ensure, therefore that senior managers approve any written submissions to a Safeguarding Adult Review prior to submission.

The expectation is that the SAR will be published and openly available. When undertaking SARs the records will be anonymised. In exceptional circumstances the Chair of the Board, in consultation with Board Members may decide that publication of the full report is not appropriate but in these rare circumstances the lesson will still be published.

13.8 Links with other reviews

Where appropriate, links should be made with Child Safeguarding Practice Reviews (CSPR) and a Domestic Homicide Reviews (DHR). Where such reviews may be relevant to SAR (e.g. because they concern the same individuals), consideration should be given to how SARs, DHRs and CSPRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can

be commissioned jointly so as to reduce duplication of work for the organisations involved, and reduce distress to the family.

In the NHS, the Serious Incident Framework provides a systematic process for responding to serious incidents in NHS-funded care. A Serious Untoward Incident process may run alongside a Safeguarding Adult Review and support the process.

Where a person who is in receipt of mental health services commits a homicide a NHS England Mental Health Homicide Review may be undertaken. Where such reviews may be relevant to SAR (e.g. because they concern the same individuals), consideration should, as above, be given to how SARs and NHS England Homicide Reviews, or Domestic Homicide Reviews, can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case.

Prior to a SAR commencing following a death, the RBSAB Chair will communicate with the Coroner as appropriate to notify them of the RBSAB intentions to conduct a SAR. Any SAR will need to take account of a Coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

13.9 Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disabilities Mortality Review (LeDeR) programme is funded by NHS England and the programme is managed by the University of Bristol, under contract to the Healthcare Quality Improvement Partnership (HQIP).

The purpose of the LeDeR Programme is to drive improvement in the quality of health and social care services delivery and to help reduce premature mortality and health inequalities for people with learning disabilities.

Its overall aims are:

- To support improvements in the quality of health and social care service delivery for people with learning disabilities.
- To help reduce premature mortality and health inequalities for people with learning disabilities.

The LeDeR program contributes to improvements in the quality of health and social care for people with learning disabilities in England by supporting local areas to carry out reviews of deaths of people with learning disabilities (aged 4 years and over) using a standardised review process. This enables them to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

LeDeR helps to identify factors which may have contributed to deaths of people with learning disabilities and develop plans of action to make any necessary changes to health and social care services for people with learning disabilities. Recurrent themes and significant issues are identified and addressed at local, regional and national level.

Anyone can refer an individual into the programme, provided there is a learning disability diagnosis. A confidential telephone number and website enables this.

Families are invited to contribute to the review process, and their contribution is valued, but there is no compulsion for them to take part.

The LeDeR programme is not an investigation. If, during or after a review of a death, the Local Area Contact has concerns which have not or cannot be addressed within the scope of the LeDeR review process, the Local Area Contact will recommend to the appropriate organisations/bodies the need for a fuller investigation (e.g. Adult Safeguarding Review).

The review works in parallel with the SAR process, Domestic Homicide Reviews and Mental Health Reviews.

13.10 Findings from SARs

SAR reports should:

- provide a sound analysis of what happened, the systems or context, why and what action needs to be taken to prevent a reoccurrence, if possible;
- be written in plain English; and
- contain findings of practical value to organisations

13.11 Learning event

The learning event will be a key activity in the process of review and will attempt to engage the multi-agency network in a series of structured and facilitated discussions about their involvement with the subject. It is an opportunity for the network to think collectively, benefit from a group enquiry in a safe environment and enhance understanding. The event will use a mix of root cause analysis tools and techniques as well as appreciative inquiry. The following questions/areas may be used as part of the structure;

- Individual agency involvement: sharing key practice events
- What worked well in this case and why?
- What did you/your agency do that you/your agency should have not done? Why?
- What could have been better?
- What needs to change?

13.12 Analysis and reporting

The final report will be completed by the independent reviewer and will pull all relevant information together, offer an analysis and findings, and appropriate recommendations. All agencies involved in the review will see the draft report and have an opportunity to comment on accuracy and fairness.

The report will be written with a view to publication, regardless of methodology used. Prior to publication, consideration must be given to media interest and a communications and media plan be put in place.

It is essential that the Coroner's Office is made aware that a review has been completed and that the competed report is forwarded to them. The Coroner's Office should also be included in the communications and media process.

13.13 Action Plan Implementation and monitoring

Single agency action plans will be submitted at the start of the review. These will usually be completed by the authors of the chronology but it is a single agency decision as to who is best placed to complete these action plans. The action plan should always be signed off by an appropriate manager.

Depending on the reports' recommendations, a multi-agency action plan will also be drawn up which specifies actions for each agency as appropriate, together with a specified time frame for them to be enacted. Individual agencies are responsible for ensuring that all actions are completed and for communicating this to the SAR sub-group. The RBSAB SAR sub-group will be responsible for ensuring ongoing actions are completed.

The SAR subgroup will receive the completed action plans and be responsible for the monitoring and oversight as required to ensure all actions are completed. Updates will be provided to the RBSAB as per subgroup reporting arrangements.

The RBSAB will include the findings from any SAR in its Annual Report and outline what actions it has taken, or intends to take in relation to those findings. If the RBSAB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation that the RBSAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

13.14 Complaints

If a member of the public has a complaint about the decision on whether to conduct a Review, the way in which the Review has been carried out or the outcomes of the Review, then they should raise this in the first instance with the RBSAB Business Unit (rbsb.admin@rochdale.gov.uk). The Manager of the RBSAB Business Unit will

review the complaint and liaise, as appropriate, with the Chair of the RBSAB to consider how the complaint should be investigated.

With the introduction of the Care Act 2014, the office of the Local Government Ombudsman (LGO) is able to look at the actions of the RBSAB. This is because the LGO considers that the RBSAB is an administrative function of Rochdale Borough Council, for the following reasons:

- Rochdale Borough Council is responsible for setting up the RBSAB
- The Overview & Scrutiny Committee and Health & Wellbeing Boards will monitor the work of the RBSAB
- Rochdale Borough Council have overall responsibility for coordinating adult safeguarding arrangements within its locality

The LGO expects someone to complain to the local authority, as the body responsible for setting up the RBSAB, before asking the LGO to consider the complaint. Details of how to complain to Rochdale Borough Council are available at http://www.rochdale.gov.uk/council-and-democracy/contact-us/complaints-and-compliments/pages/complaints---social-care-servi.aspx

The extent to which the LGO will look at a complaint about the actions of a Safeguarding Adults Board are explained in detail in Appendix 1 of the LGO Guidance Statement, which is available at https://www.rbsab.org/the-board/

However, as the RBSAB is considered to be an administrative function of Rochdale Borough Council, they must be allowed to consider any complaint before it is referred to the LGO. More details are available at www.lgo.org.uk/make-a-complaint

Appendix	**Document**	**File**
Appendix 1	SAR Methodologies and Tools	SAR Methodologies and Tools.docx
Appendix 2	SAR Referral Form	SAR Screening Form
Appendix 3	SAR Screening Flowchart	SAR Screening Flowchart and Times