Wiltshire Safeguarding Adults Board

Safeguarding Adults Review Policy 2019

Purpose

The purpose of this document is to provide a local framework for initiating and conducting Safeguarding Adults Reviews (SAR). This guidance is for those involved in managing and taking part in reviews to ensure that all partners fulfil their statutory responsibility to carry out and engage with Safeguarding Adult Reviews.

When should a Safeguarding Adults Review take place?

One of the Safeguarding Adults Board's core statutory duties is to conduct any SAR in accordance with Section 44 of the Care Act 2014.

Under the statutory requirements of the Care Act 2014, a Safeguarding Adults Board (SAB) must arrange a SAR when:

> An adult 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 adult (s.14.133).

SABs must also arrange a SAR if:

> An adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, it would have been likely that the individual would 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 also free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support (s.14.134).

In all cases, **the adult must have needs for care and support**, but does not have to have been in receipt of care and support services for a SAR to be considered.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Essentially, **SARs are concerned with the abuse or neglect of adults with care and support needs, who are not able to protect themselves because of those care and support needs.**

In summary, a SAR must take place when **both**:

1) An adult with care or support needs who is resident in Wiltshire has died of, or been seriously harmed by, abuse or neglect (whether known or suspected).
2) There is concern that partner agencies could have worked more effectively to protect the adult.

What is a Safeguarding Adults Review?

Safeguarding Adults Reviews are undertaken to:

- Determine what the relevant agencies and individuals involved in a case could have done differently, that may have prevented serious harm or death
- Establish what can be learned from the case
- Apply that learning to future cases to prevent similar harm occurring again

SARs are not inquiries into how an adult with care and support needs died or who is culpable; that is a matter for Coroners or Criminal Courts to determine as appropriate. The purpose of a SAR is not to hold any individual or organisation to account - other processes exist for this, including:

- Criminal proceedings
- Disciplinary procedures
- Employment law and systems of service and professional regulation, such as the Care Quality Commission (CQC), 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 are safe experiences that encourage honesty, transparency and sharing of information in order to obtain maximum benefit from them. If individuals and organisations are fearful of SARs, their response will be defensive and their participation guarded and partial (s14.140).

The purpose of a SAR is not to re-investigate an incident or incidents, nor is it to apportion blame but to identify whether lessons can be learnt about the effectiveness of professionals and agencies working together to safeguard adults at risk.

Making a referral

It is the responsibility of those who work with adults with care or support needs to make a referral for a SAR where there are reasonable grounds to consider that the criteria, as set out above, may be met. When deciding whether to make a referral, there are four key questions to consider:

- Does the adult involved have care or support needs?
- Has serious abuse or neglect taken place? (statutory guidance sets out that 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, or the individual has died as a result)
- Is the adult living in, or were they subject to abuse or neglect in, Wiltshire?
- Could agencies have done more, by working together, to protect the adult from abuse or neglect?

If the answer to all of the questions above is yes, a referral must be made.

A SAR may also be considered where the Board believes there would be value in doing so, or it is in the public interest. However, referrals **must be made** in the above circumstances.

Partner agencies should not draw their own conclusions on whether the criteria is met when that is not immediately clear, but should make a referral to the SAB in order for this decision to be made.

All referrals should be made using the form in Appendix 1 and sent to LSAB@wiltshire.gov.uk

A SAR can be requested by any partner agency, any designated adult safeguarding officer, the Coroner or the Secretary of State.

Enquiries about the referral process can be made by phone to 01225 718093.

Decision-making Process

Once a SAR referral is received, the independent WSAB Chair is advised. All agencies identified as having been in contact with the Adult at Risk will then be asked to:

- Secure records related to the individual
- Provide information to the SAB in order for the SAR Panel to assess the referral (the form those agencies are asked to complete is attached at Appendix 2).

The final decision about whether a SAR will be commissioned rests with the SAB Chair; however, the Chair will be advised by the Safeguarding Adults Review Panel who will consider the request and make recommendations to the Chair.

The panel receives all SAR referrals and considers whether the referral meets the criteria to conduct a SAR, or whether any other action should be carried out to ensure learning takes place. The panel makes recommendations to the Board Chair who decides on whether a SAR will be commissioned.

The SAR Panel consists of senior representatives from statutory partners of the Board and a Panel Chair, appointed by the Board Chair:

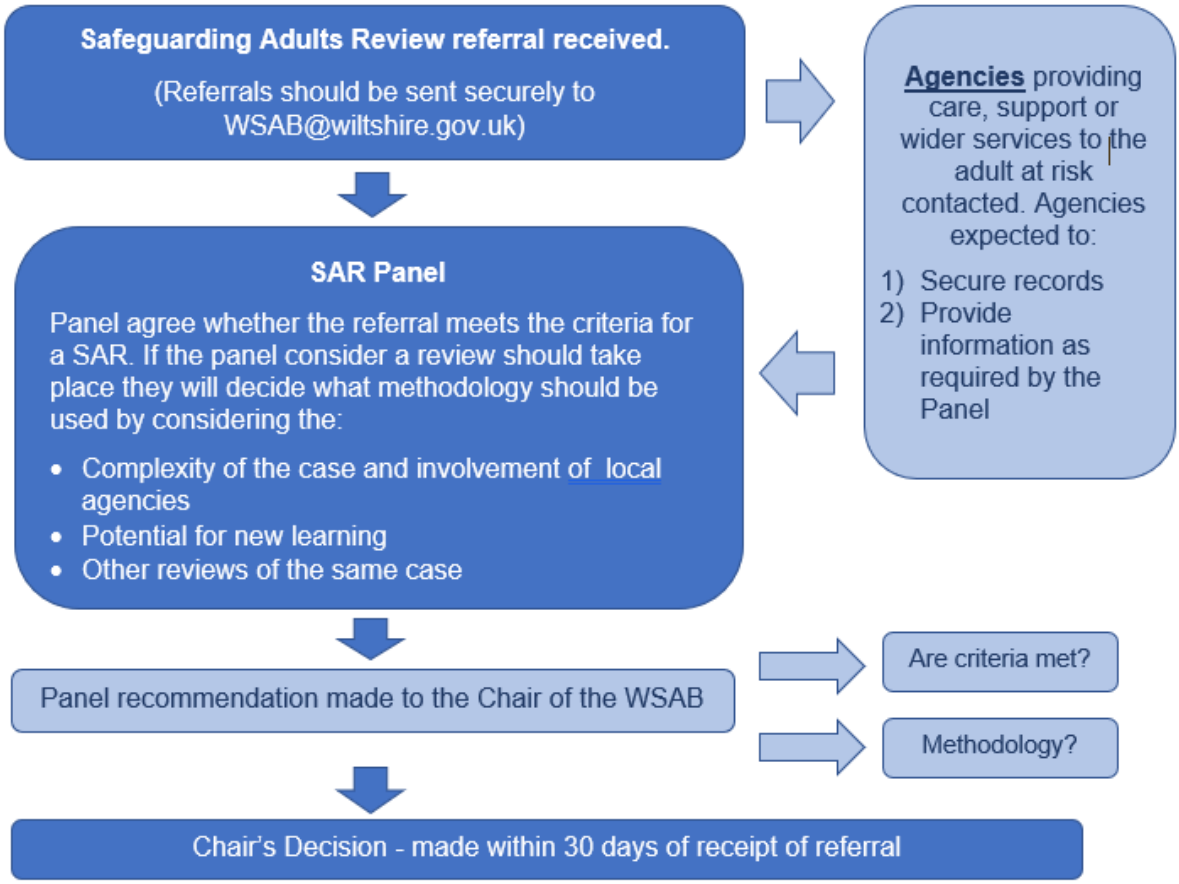
- Panel Chair (appointed by the WSAB Chair)
- Partnership Board Manager (see below)
- Wiltshire Police
- Wiltshire Council
- NHS Wiltshire Clinical Commissioning Group

The SAR Panel will assess whether the criteria for a SAR have been met and the potential methodology of any review, before making a recommendation to the SAB Chair.

The decision on whether a SAR will take place must be made within a month of receipt of the referral. However, there may be reasonable grounds for the Chair to extend this period on the basis of other reviews of the same case, or criminal proceedings, to ensure all of these necessary processes are unimpeded and that the SAR does not duplicate those other processes.

All Board members will be informed when a SAR is taking place. In the event of an application being turned down, the reasons need to be recorded in writing by the Chair and shared with the applicant.

Wiltshire Safeguarding Adults Board - commissioning SARs



Choosing a SAR methodology

WSAB's primary concern is to promote effective learning and improve action to prevent deaths or serious harm occurring again in the future.

Safeguarding Adults Boards across the country have used a whole range of review methodologies and all of these have the potential to help achieve learning. However, all cases are different, and different means of examining past practice will most effectively allow us to improve future practice.

"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 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." (Care Act statutory guidance 14.141)

In selecting a methodology, the SAB will consider:

- How best to promote effective learning and improve actions to prevent death or serious harm
- How to avoid a hindsight bias which may obscure analysis of complex situations
- How to promote a broad organisational learning approach and reflect current practice realities.

WSAB's Safeguarding Adults Review Panel will consider a range of methodologies including traditional models like **the SCIE Learning Together model** and the **Significant Incident Learning Process (SILP**), and more local approaches including a **Local Learning Review (LLR)**. The Panel will evidence their discussion and provide rationale for their recommendation to the Chair of the Board.

The review methodology will be proportionate to the circumstances of the case. In all cases the Panel and the Chair will consider whether the reviewer commissioned to undertake the review has the following:

- No prior involvement in the case being reviewed
- Independence from organisations involved in the review process
- Strong leadership and the ability to motivate others
- Facilitation skills and the ability to handle multiple perspectives and potentially sensitive or complex group dynamics
- Collaborative problem-solving experience and knowledge of participative approaches
- Good analytical skills and the ability to manage qualitative data
- Safeguarding knowledge
- A determination to promote an open, reflective learning culture (s14.143).

(This list is based on the Working Together to Safeguard Children guide to interagency working to safeguard and promote the welfare of children).

All reviews will consider both frontline practice and organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for adults at risk. However, the nature of the review must and will consider:

- What other reviews are being undertaken at a single agency and multi-agency level (as set out below)
- Whether commencement of a full review would benefit from coming after the conclusion of police investigations and/or Coroner's inquiries

Other review processes

A decision on methodology will be based on the complexity of the case and the potential to identify learning. That decision will also be influenced by:

1) Other multi-agency review processes (for example if a Domestic Homicide Review, other safeguarding case review or Learning Disabilities Mortality Review (LeDeR) are already taking place) and are assessed to be sufficient to generate learning.
2) Substantial work has been done by single agencies to review the case (for example Root Cause Analyses, Independent Office for Police Conduct Review etc) which have identified learning.
3) The case is historic and evidence demonstrates that practice has changed so substantially since the harm occurred that the review would fail to identify relevant learning.
4) The case is similar enough to another case already reviewed by the SAB that learning is considered to have already been established.

In the case that 4) applies, agencies involved will be asked to provide a written report outlining how learning from the original SAR was implemented and explaining how those processes have failed to prevent future harm. These reports will then be considered by the SAR Panel and Board Chair before a decision is made on the commissioning of a SAR.

The SAR Panel will consider a SAR approach proportionate to the complexity of the issues to be considered. However it is considered by the Wiltshire SAB that a **Local Learning Review** can and should be as effective as more traditional approaches to SARs.

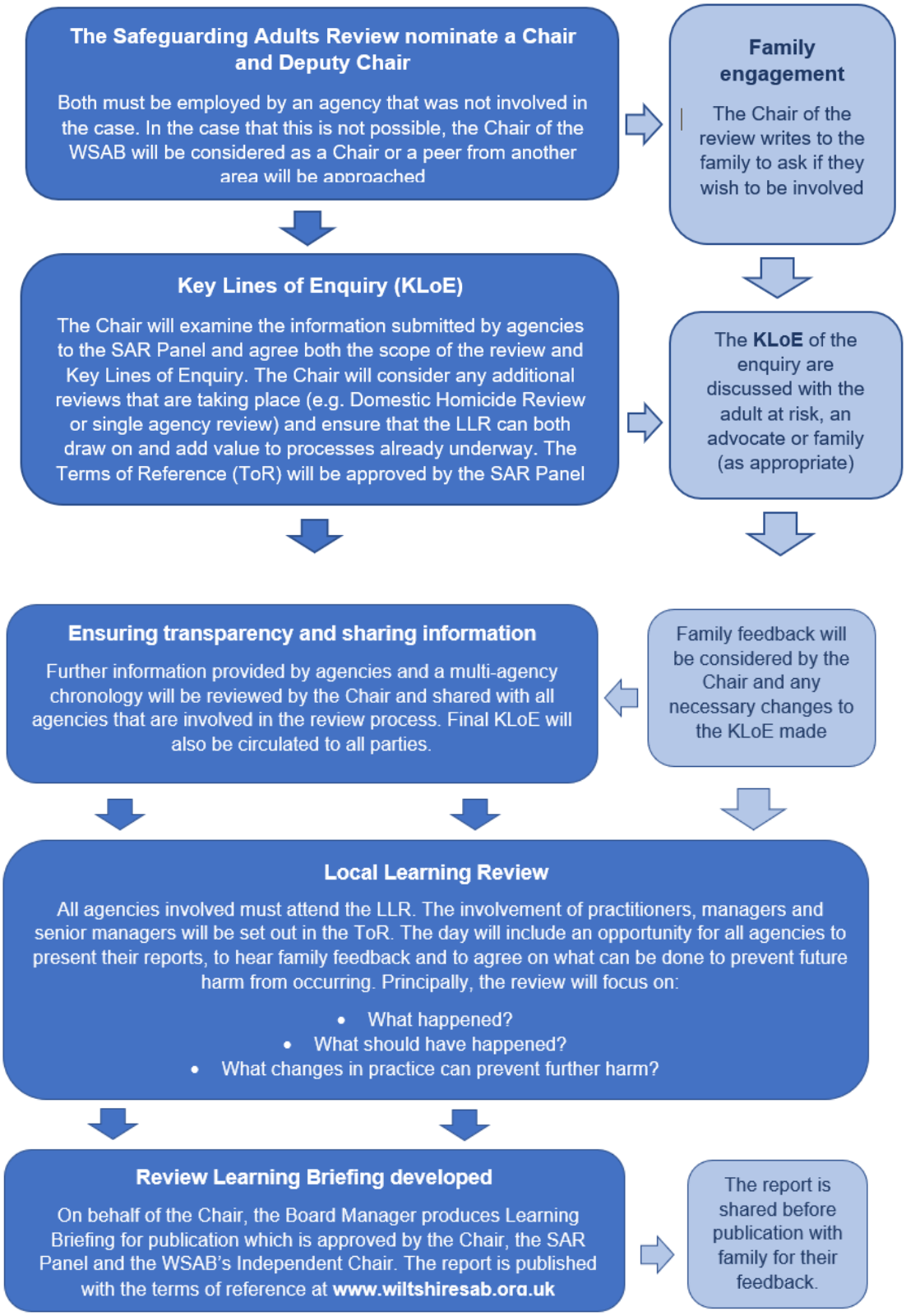
Local approach

A Local Learning Review (LLR) process has been designed in Wiltshire and is set out below. It focuses promoting a culture of reflection and local learning by harnessing local expertise to Chair and run a review.

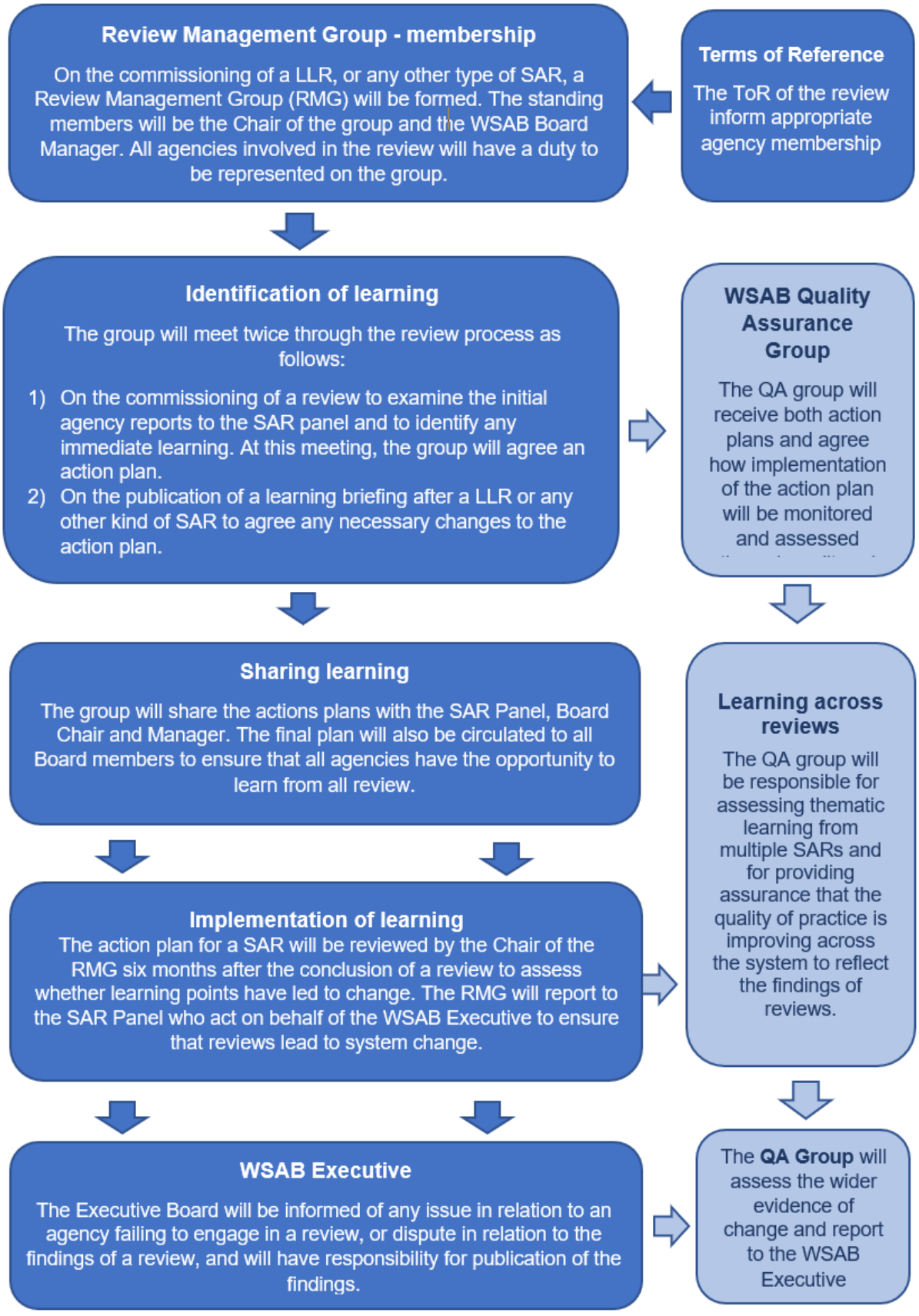
A Chair and a Deputy Chair are selected from agencies that have not been involved in the provision of services to the adult at risk. They run a desktop review, meet with family and provide oversight of a learning briefing. Additional oversight is provided by the SAR Panel and the Independent Chair of the WSAB.

The first flowchart below sets out this process, the second flowchart sets how learning is acquired from an LLR.

Local Learning Reviews (LLR)



Learning from reviews



The key principles of adult safeguarding apply to all our SAR activity, namely:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

Safeguarding Adults Reviews and other case reviews should be conducted in a way which:

1. Recognises the complex circumstances in which professionals work together to safeguard adults with care and support needs.
2. Is proportionate according to the scale and level of the complexity of the issues being examined
3. Ensures independent oversight by individuals who were not involved in the case under review
4. Seeks to understand precisely who did what and the underlying reasons that led to individuals and organisations acting as they did
5. Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight
6. Professionals are fully involved in reviews and can contribute their perspectives without fear of being blamed for actions they took in good faith
7. Ensures that the voice of the adult at risk is heard, where possible by asking them to contribute themselves and, where that is not possible, by involving an advocate and/or speaking to families.

The SAR Panel will supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality.

The focus of a SAR is on the prevention of future harm through the attainment of learning - the characteristics of a review that achieve this include:

- Timeliness
- Family engagement: adults at risk, their advocates and their families being given a voice and a role in the review process. The statutory **Duty of Candour** places a requirement on providers of health and **adult** social care to be open with people and their families when there are failings or things go wrong.
- Transparency: most readily achieved through publication. The learning as a result of a **Safeguarding Adult Review** needs to be shared.
- Objectivity: achieved by having a Chair that has not had personal or organisational involvement in the case
- Rigour: provided by the agreeing of Key Lines of Enquiry that the Board agrees, challenging agencies to examine past practice
- Local ownership: a review should enable and promote local reflection on local practice
- Sharing of information: local agencies should, through the process, gain a better understanding the work of their partner agencies

The panel will be guided by SCIE's Safeguarding Adult Review Quality Markers Checklist.

When the criteria for a SAR has not been met

A Safeguarding Adults Review is not the only mechanism for establishing learning or for examining failings in practice. In some cases, despite serious harm having occurred, the criteria for carrying out a SAR will not have been met because:

1) The adult did not have care of support needs, so safeguarding processes do not apply
2) There is no indication that abuse or neglect have occurred
3) Partner agencies could not have worked together more effectively to protect the adult

In the case that 1) or 2) apply, the Board will ensure that any other review mechanisms have been considered (i.e. the Domestic Homicide Review Process, criminal proceedings and single agency review processes).

However, in the case that only 3) applies, the SAR Panel may consider asking a single agency to review practice and to report back to the SAR panel on what changes have been implemented to prevent future deaths or harm occurring. This will ensure that the Board can provide assurance that all agencies are working to effectively safeguard adults at risk.

The Board may also consider audits of multi-agency and single agency practice as a response to a SAR referral where criteria have not been met.

Timescales

A decision as to whether a referred case meets the threshold for a SAR will be communicated to the referrer within one month of receipt of the referral.

SABs are expected to complete a SAR in a 'reasonable period of time' and within six months of initiating the review. A longer period is permitted, for example, because of potential prejudice to related court proceedings (s14.144).

The SAB will complete each review within six months of the Chair confirming that a SAR is being commissioned and a Chair having been agreed. If the SAR is not complete after six months, the SAB Executive will be informed.

Duty to cooperate

SAB partners will ensure there is appropriate involvement in the review process of professionals and organisations involved with the adult subject to the review. Agencies that are members of the Board are expected to fully cooperate with any review that is initiated, whether it is a SAR or other learning review.

The SAB will ask each relevant organisation to provide information in writing about its involvement with the adult who is the subject of the review. The form in which such written material is provided will depend on the chosen review methodology.

The SAB will notify each organisation that is a partner of the SAB of the decision to initiate a SAR, and what is expected of each organisation as part of the review. This notification will be sent to the Board Member or Chief Executive of the relevant organisation. This notification will request the senior manager to:

- ensure all agency records relating to the case are made secure
- identify a senior representative to be a member of the review panel
- confirm whether there are any other investigations/review processes taking place or proposed

Implementation of learning

The WSAB will ensure that the learning process begins at the outset of the SAR process in order to ensure that, at the time of the final publication of a SAR, work has already begun to make any necessary operational changes.

When a SAR is commissioned, a Review Management Group (RMG) will be formed. The only standing members of that the RMG will be its Chair and the Board Manager. Other RMG members will be representatives from any agency that is involved in the SAR. The RMG will be governed by the SAR Panel and its Chair will be a standing member of the Panel.

It will be the role of the RMG to:

- Develop a learning plan based on the information available - this will be done at two points in the process. Firstly, when a SAR is commissioned, at which stage the action plan will be based on information already provided to the SAR Panel. At this stage the intention will be to mitigate or reduce risk where it is possible to do so before the review is complete. Secondly, on the publication of the SAR report at which time key learning points will have been established.
- Report to the SAR Panel on the progress agencies are making to implement actions and learning.
- Ensure each agency participating in the SAR has identified a representative to take part in the RMG. That representative must have:

    - sufficient seniority and authority to represent the agency and commit it to actions agreed as part of the review.
    - relevant professional experience to allow them to analyse information and acknowledge evidenced weaknesses in their agency's involvement.
    - It is essential that panel members have not had any direct involvement in the case being reviewed or have any other conflicts of interest which may impinge upon the work of the SAR. At the nomination stage, each agency will be required to confirm this professional distance from the case in question and that the panel member will be available to participate fully in the review until its conclusion.

Responsibilities of agency representatives:

- to represent their agency in review discussions
- to liaise closely with whoever is preparing their agency's reports to ensure that the report addresses all the relevant issues and is submitted according to agreed timescales
- to clarify any information sharing issues
- to seek legal advice on behalf of the agency if required
- to ensure the report and subsequent actions arising from the review, have received approval at the appropriate level
- to arrange for a chronology of their agency's involvement in the case to be produced as requested
- to analyse and contribute to panel discussions about the various agency reports to assist the panel in reaching its conclusions
- to identify who within their agency will be responsible for monitoring and reporting on the relevant sections of the action plan
- to act as a critical friend to other panel members

The **learning plan** will be approved and overseen by the SAR Panel, which will provide feedback to the WSAB Executive. The Board will, as a minimum:

(i) Publish the SAR report (unless there are exceptional circumstances which mean that publication cannot take place)
(ii) Ensure the production and dissemination of a SAB practice briefing note for all agencies to highlight key messages for use within individual supervision and team/staff meetings. The practice briefing note will also be disseminated to training providers to ensure the content is included within / informs safeguarding adults training.

Practitioners' responsibilities: anyone who works with Adults at Risk in Wiltshire should actively engage with the learning opportunities provided by SARs. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- reading WSAB SAR publications
- reading WSAB SAR briefing notes
- attending appropriate single and inter-agency training
- contributing to staff and team meetings / supervision
- supporting colleagues and staff in other agencies in implementing the learning from SARs

Appendix 1

Wiltshire Safeguarding Adults Board

Safeguarding Adults Review referral form

Statutory requirements of the Care Act 2014

A Safeguarding Adults Board **must** arrange 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 concern that partner agencies could have worked more effectively to protect the adult (s.14.133).

SABs **must** also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to die 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 in any other situations involving an adult in its area with needs for care and support (s.14.134).

The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

Referral process

The **Wiltshire Safeguarding Adults Board** SAR Panel will consider every referral on the basis of whether it meets the criteria for a Safeguarding Adults Review. The Panel needs as much information as possible to enable its members to make a proportionate decision as to how to respond to a case referral, ensuring, if the case is accepted for a review, that that maximum learning is achieved for the Safeguarding Adults Board.

Please complete the form below providing as much information possible for the panel to consider:

i. Referrer – your details

Name:	
Role:	
Organisation:	
Contact details:	

ii. Adult being referred

Adult involved	
Name:	
Date of birth:	
Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
Agencies you are aware are, or have been, involved with the adult:	

iii. Referral reason(s)

How does this case meet the criteria for a Safeguarding Adults Review? Please explain against each criterion set out under the statutory requirements explained at the top of this form.	**Please note – A review is carried out when an adult at risk has been abused or neglected, or it is suspected they have been, and there is concern that partner agencies could have worked more effectively to protect the adult**
What learning do you think can be achieved through review of this case?	
Which agencies / services should particularly achieve this learning?	
What other learning / review processes have been followed? (please detail) What did they achieve? (please detail) How has that learning been disseminated? (please detail) What impact has it had? (please detail)	

Please detail any other relevant information that will enable the Safeguarding Adults Review Panel of the WSAB reach a decision about how to respond to this referral.	

Appendix 2

Safeguarding Adults Review (SAR)

Case Review Proforma

A referral has been received by Wiltshire Safeguarding Adults Board to consider holding a Safeguarding Adults Review to consider the death, or serious abuse/neglect of:

i) **Adult deceased/ at risk**

Name:	
Date of birth:	
Date of death (where applicable) and/or detail of risk/abuse identified:	
Address:	

It is understood that the following agencies had contact with the individual:

Agencies involved:	

Notification

It is expected that the agencies/organisations above will fulfil their agreed duty to cooperate by providing information in writing about involvement with the adult who will be the subject of any review. The form in which such written material is to be provided is set out below.

This notification is to be sent to the Board representative (or Chief Executive) of each organisation as applicable. This notification will request the senior manager to:

- Provide relevant information as indicated below
- ensure all information sent to the WSAB is sent securely
- identify a senior representative to be a member of a future review panel
- confirm whether there are any other investigations/review processes taking place or proposed

ii) Case Review detail:

Agency:	
Author of submission:	
Job title:	
Telephone number:	
Email address:	

iii) Adult at Risk – case history

Brief summary: overview of case record relating to the adult (include details of any records reviewed to complete this)	
What level of risk was posed/believed to be posed to the adult at risk at the last point of agency contact?	
If agency contact with the individual ceased, please outline when and how this decision was reached	
What referrals (either formal and informal) were made to other agencies concerning the individual? Please include dates	
Was the individual's capacity for decision making assessed when, and if, appropriate? Please list assessments with dates, if relevant.	
How was wider risk, related to the circumstances of the individual assessed, communicated and mitigated?	
Was/has contact with family/friends of the adult at risk been established and how did this impact on the role of the agency/organisation?	

What reviews/plans have been developed as a result of this case/outcome?	**Copies of all relevant documents, reviews and plans should be submitted with this form, to be considered by the SAR panel.**
What learning / actions has been established and implemented as a result of this outcome?	
Chronology completion	**A chronology of key contacts and decisions should be completed as set out below.**

iv) Chronology

Date	Time (where relevant)	Organisation	Event/contact/decision made	Impact on adult at risk	Comments