Leicester
Safeguarding
Adults Board

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Leicester Safeguarding Adults Board

Safeguarding Adults Review (SAR) Policy

Conducting safeguarding adults reviews in Leicester under Section 44 of the Care Act 2014

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FOREWORD

One of the core duties of a Safeguarding Adults Board (SAB) is to review cases in its area (in this instance Leicester) where an adult with needs for care and support:

- Has died and the death resulted from abuse and neglect, or
- Is alive and the SAB knows or suspects that they have experienced serious abuse or neglect

Importantly, safeguarding adults reviews are about how agencies **worked together** to safeguard adults; they are in their nature multi-agency reviews. For a review to be mandatory in legislation, there must be reasonable cause for concern about how the SAB, its members (or others with relevant functions) worked together to safeguard the adult.

> *IN ORDER TO ACHIEVE THE AIMS OF SAFEGUARDING, IT IS IMPORTANT TO 'SUPPORT THE DEVELOPMENT OF A POSITIVE LEARNING ENVIRONMENT ACROSS THESE PARTNERSHIPS AND AT ALL LEVELS WITHIN THEM TO HELP BREAK DOWN CULTURES THAT ARE RISK-AVERSE AND SEEK TO SCAPEGOAT OR BLAME PRACTITIONERS'*
>
> *(DEPARTMENT OF HEALTH AND SOCIAL CARE STATUTORY GUIDANCE)*

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1. Introduction

1.1 Purpose of Policy

The purpose of this policy is to outline the process for the management of notifications of Safeguarding Adults Reviews (SARs) in Leicester under Section 44 of the Care Act 2014. This protocol has been developed to simplify and clarify our local process by:

- Providing an overview of how to notify serious incidents which may be suitable for review
- Enabling a consistent approach to SAR decision making and practice
- Demonstrating how local processes comply with legal requirements and best practice
- Clarifying review timeliness in line with legislation and statutory guidance
- Providing a resource to enable those involved in reviews to answer common questions
- Clarify local roles and responsibilities
- Provide transparency about the review process
- Support practical planning and preparation of reviews

1.2 Legislation and Statutory Guidance

The Care Act 2014 outlines a Safeguarding Adults Board's core duty to conduct safeguarding adults reviews in accordance with Section 44 of the Act, which can be found here: http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

Statutory Guidance published by the Department of Health and Social Care in relation to safeguarding adults reviews can be found here: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

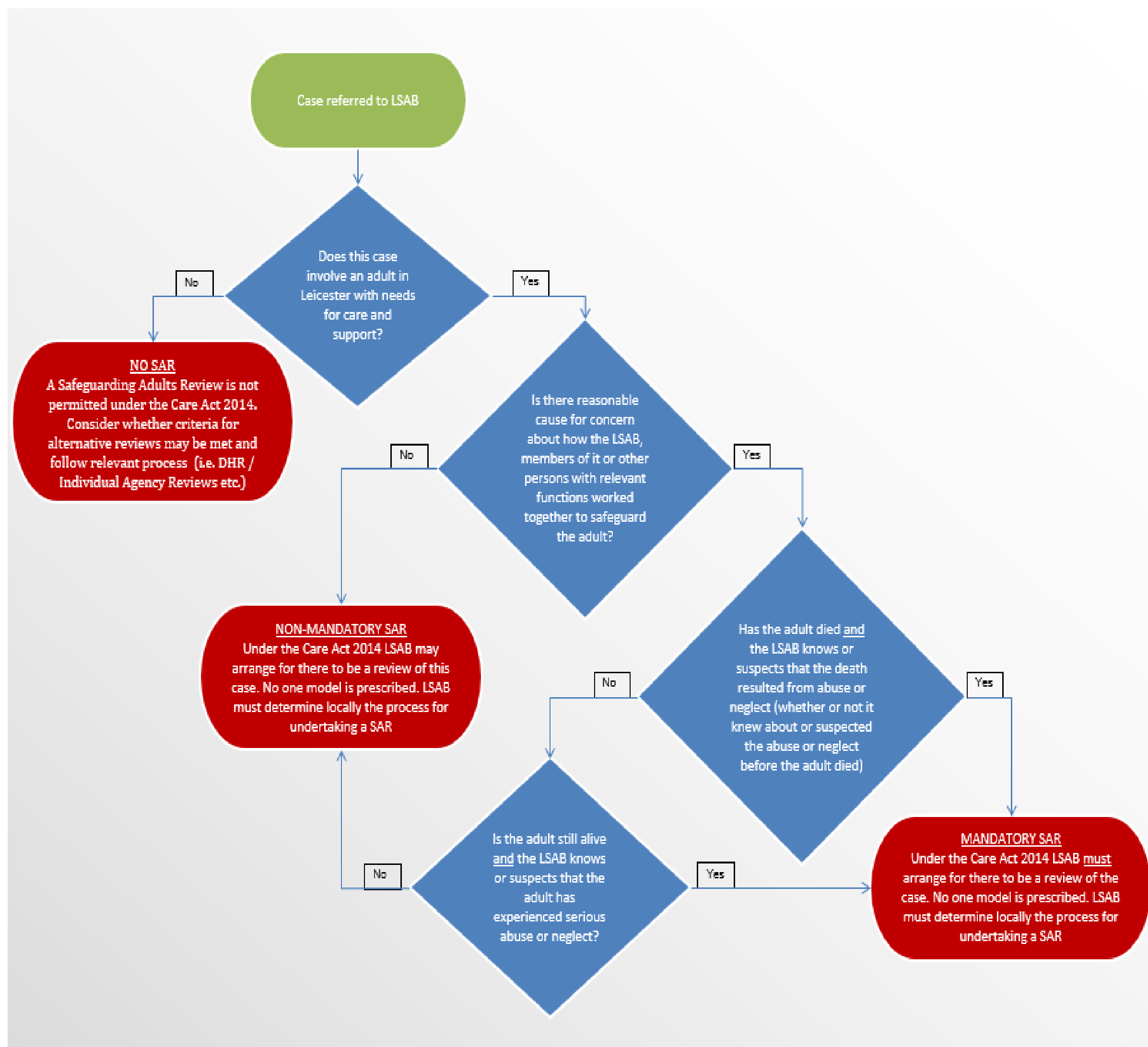
2. Purpose of a SAR, Local Process, & Timelines

2.1 Purpose of a SAR

The purpose of a SAR is noted in the Statutory Guidance as being to:

'promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. 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… SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.'

2.2 SAR Criteria



The criteria for conducting a safeguarding adults review can be found under Section 44 of the Care Act 2014 (see above link). Locally, a flowchart has been developed to support the Safeguarding Adults Board with making decisions about whether or not these criteria have been met:

2.3 Referral & Decision

SAR referrals should be made via an organisation's safeguarding lead, using the LSAB SAR referral form (Appendix 1) and e-mailed to lsab@leicester.gcsx.gov.uk.

Upon receipt of the referral, the LSAB Board Office will, within 5 working days, send an email to the referrer confirming receipt. The LSAB Board Office will also notify the following individuals that the referral has been made:

- LSAB Independent Chair
- LSAB Legal Advisor
- LSAB Review Subgroup Chair
- LSAB Board Manager
- LSAB Board Officer

The referral must be heard at the next scheduled meeting of the LSAB Review Subgroup (unless the LSAB Review Subgroup Chair determines that it must be heard sooner, in which case an extraordinary LSAB Review Subgroup meeting will be called). The referral must be heard **within 5 weeks** from the date that it is received.

After the SAR referral has been heard, the LSAB Review Subgroup may decide to undertake a trawl of information to support the decision-making process. Where this is required, the trawl should be completed, and relevant information provided by organisations, **within 10 working days** of receiving the initial trawl request and in time for the information to be considered as part of the Board Manager Report at the subsequent LSAB Review Subgroup.

Having considered the SAR referral (and where relevant, the subsequent trawl information) it will be the responsibility of the LSAB Review Subgroup to make a recommendation to the LSAB Independent Chair about whether or not to commission a safeguarding adults review (see Appendix 2 for relevant form). The LSAB Independent Chair will notify the LSAB Review Subgroup of their decision.

2.4 Review Timeline

Section 14.173 of the Statutory Guidance states, '*The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings'*.

To ensure that reviews are completed in line with statutory guidance, the following timeframes for safeguarding adults reviews have been agreed locally:

SAR referral and decision

Action	Timeframe
Referral made	As soon as is reasonable after case has been identified
Referral heard at Review Subgroup meeting 1	Within 5 weeks from initial referral
Trawling letters issued	Within 1 day of Review Subgroup meeting 1
Trawl return: Organisations provide either 'Nil Return' or 'A4 Summary'	Within 10 working days of request for information
Board Manager Report prepared (incorporating trawl returns)	In time to go out with papers for Review Subgroup 2 meeting (to be held the month after Review Subgroup 1 meeting)
Review Subgroup make recommendation to LSAB Independent Chair	As soon as is practicable once it is agreed that there is enough information available to make a recommendation

Completion of SAR within 6 months of it being initiated

Action	Timeframe	Month
LSAB Independent Chair commissions SAR	Day 0	1
LSAB Board Office requests chronologies	Day 1	1
LSAB Board Office informs HM Coroner of intention to commission SAR (in relevant cases)	Day 7	1
LSAB Board Office informs statutory LSAB Board Members of intention to commission SAR	Day 7	1
LSAB Board Office informs Senior Investigating Officer (SIO) of intention to commission SAR (in relevant cases)	Day 7	1
Safeguarding leads arrange for chronologies to be completed and returned to LSAB Board Office	Day 15 (This allows 2 weeks for simple chronologies to be completed. No analysis required at this stage)	1
LSAB Board Office combines chronologies and sends out with papers for Review Subgroup meeting 3 along with updated Board Manager report including: draft terms of reference, proposed methodology, draft scoping period, and proposed review membership	Day 21	1
At Review Subgroup meeting 3, Review Subgroup members confirm draft terms of reference, scoping period, review membership, and SAR methodology	Day 28	1
Board Manager in conjunction with LSAB Review Subgroup Chair, commissions independent SAR author taking into account chosen methodology	Between days 28 and 42 (This allows 2 weeks for SAR author to be commissioned)	2
LSAB Board Office makes contact with individual involved in the review (if still alive, or family of the deceased if not)	Day 35	2
At Review Subgroup meeting 4, update on progress to be provided by LSAB Board Office	Day 56	2
Independent SAR author reviews draft terms of reference, scoping period, and review membership, and in conjunction with SAR panel members and LSAB Board Office, confirms which agencies are to provide Individual Management Review (IMR) reports and which agencies are to provide Summary Reports (or other reports/input dependant on chosen methodology)	Day 60 (This allows 2-3 weeks for Independent SAR author having been commissioned, to read up on the material gathered to date and review terms of reference etc.)	3
IMR Briefing date set and Safeguarding leads informed of this date	Day 63	3
Safeguarding leads to identify IMR / Summary Report authors and inform LSAB Board Office	Day 74	3
At Review Subgroup Meeting 5, Review Subgroup members to have oversight of and agree proposed changes to terms of reference, scoping period, panel membership etc	Day 84	3
LSAB Board Office to facilitate IMR Briefing	Day 85	3
Safeguarding leads arrange for IMR / Summary Reports to be completed and returned to LSAB Board Office	Day 127 (This allows 6 weeks from the date of the IMR briefing to completion of the IMR reports)	4

Learning extracted (this part of the SAR process will be dependent on the methodology chosen. It may involve a one-day learning event or a series of panel meetings, a desktop review, or a multi-agency audit etc)	Between days 127 and 155	5
First draft of Overview Report written and shared, followed by amendments, subsequent drafts and senior officer sign off	Between days 156 and 186	6

Executive Summary, Overview Report and Action Plan is then tabled at:

A. LSAB Review Subgroup for information, to reflect on the review process, and for quality assurance
B. LSAB Board Meeting for final sign off, and decisions around publication

3. Contact with the Individual at the Centre of the Review and/or Their Family

3.1 Statutory Guidance & Best Practice

The ADASS and LGA publication 'Making Safeguarding Personal for safeguarding adults boards' (Lawson, 2017) recommends that '*Safeguarding adult reviews (SARs) and other review processes engage with people in receipt of support and services and/or their families'*[1]

Department of Health and Social Care statutory guidance outlines the following in relation to the adult, their family, and friends when it comes to SARs: *'7.3 There is also a separate duty to arrange an independent advocate for adults who are subject to a safeguarding enquiry or Safeguarding Adults Review (SAR)…*

14.54 The Care Act requires that each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them…

14.165 Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.'

3.2 Local Approach

Engagement of the individual at the centre of the review and/or their family will be authorised by LSAB Review Subgroup and facilitated by the LSAB Board Office. To enable the individual and/or their family to be fully briefed on what to expect from the review, contact will be made after the review methodology has been agreed. However, wherever possible contact must be made early enough to enable the individual and/or their family to contribute to the terms of reference of the review should they choose to.

[1] Lawson, J (2017) 'Making Safeguarding Personal for safeguarding adults boards' ADASS; LGA

LSAB Board Officer will be the main point of contact for the individual and/or their family throughout the review. Early discussions will take place to agree how they wish to be involved. Should an independent advocate be required, LSAB Board Office will liaise with Leicester City Council Adult Social Care in order to arrange this.

Advice from the individual at the centre of a review and / or their families who have been involved in Leicester City, Safeguarding Adults Reviews:

- Talking through the final report without rushing is helpful, as is taking time to explain what things mean.
- Being able to ask questions and to understand what is happening was helpful.
- Whilst it is important to find out 'what' happened, we feel that it is as important to find out 'why' it happened.
- Having one contact person throughout and regularly being kept up to date (even if nothing was happening) was good for us.
- The review process has helped us to move on a little.

Where such services exist, consideration should be given to signposting the individual and/or their family to support services independent of the review. One such example is AAFDA who in certain circumstances would be able to offer independent guidance and support throughout the review https://aafda.org.uk/

4. Roles and Responsibilities:

4.1 LSAB Independent Chair:

- Decide whether or not a SAR should be undertaken
- In conjunction with LSAB Board Members, sign off final Overview Report, Executive Summary and Action Plan ensuring that multi-agency recommendations have Specific Measurable Achievable Realistic and Timebound (SMART) actions and clear action owners
- In conjunction with LSAB Board Members make a decision about publication

4.2 LSAB Review Sub Group Members:

- Scrutinise and analyse information provided to support the group in making recommendations to the LSAB Independent Chair
- Coordinate additional information from own agencies as required to make a recommendation about whether or not to commission a SAR
- Coordinate chronology from own agency
- Determine SAR methodology
- Agree draft Terms of Reference
- Agree draft scoping period
- Confirm organisations to be involved in the review. Confirm initial membership of panel (or attendance at learning event etc. dependant on the review methodology)
- Approve any changes to Terms of Reference and scoping period

- Approve any changes to panel membership
- Ensure that relevant members of own organisation (including Board Member, IMR author, SAR Panel Member) are updated about commissioned SARs (including sharing review timeline, terms of reference, emerging learning as appropriate)
- Quality assure final draft of Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners
- Ensure own organisation is adequately represented at relevant meetings (i.e. Review Sub Group meetings, SAR panel meetings, SAR publication meetings) and in key discussions
- Review Sub Group chair to chair SAR publication meetings
- Ensure that individual agency learning from SARs is shared within own organisation and that assurance is provided to the LSAB Training Sub Group that this has been done
- Be the main point of contact within own organisation for single agency SAR actions updates

4.3 Panel Members / Review Participants:

- Attend and contribute to panel meetings (or learning events / audits etc depending on methodology used)
- Contribute agency information and/or specialist knowledge to the review
- Support the development of a positive learning environment across the partnership and support the SAR author to extract learning from the review
- Analyse information provided and support the SAR author to develop review recommendations
- Have an awareness of the legislation and statutory guidance in relation to SARs and ensure that appropriate learning is developed whilst adhering to review timelines
- Quality assure drafts of Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners
- Arrange for sign off (at senior officer level) final draft reports prior to them being sent to Review Subgroup and the Board

4.4 Board Office:

- Project manage SARs to ensure that they are completed to a sufficient standard within an appropriate timeframe
- Prepare Board Manager report including draft terms of reference, draft scoping period, proposed methodology, initial panel membership and proposed timeline for the Review Sub Group's consideration
- In conjunction with LSAB Review Subgroup Chair, commission independent SAR chair/author
- Inform individual central to the review and/or their family about the SAR and remain point of contact throughout
- Provide regular updates on SAR progress both verbally and in writing at Review Sub Group
- Request and collate single and multi-agency SAR actions updates

4.5 SAR Independent Chair/Author/Facilitator:

- Review the initial panel membership
- Review and confirm Terms of Reference
- Review and confirm scoping period
- Notify LSAB Review Subgroup (who will maintain oversight) of any changes to scoping period, panel membership, terms of reference throughout the review

- Facilitate review in line with the chosen methodology
- Produce Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners

5. Resolving Disagreements:

Where disagreements occur, they are to be resolved wherever possible through the SAR methodology chosen (i.e. one-day learning event / traditional serious case review model with panel meetings). There is also the option for disagreements to be escalated in line with the LSAB Constitution. However, to maintain the independence of the SAR author, ultimately any disagreements which cannot be resolved will be noted in the Overview Report.

6. Information sharing and retention:

Section 44 of the Care Act 2014 states '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'. Section 45 of the Care Act 2014 outlines compliance in relation to supply of information and can be read here: http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

The LSAB's multi-agency information sharing agreement can be found on the Safeguarding Adults Boards Multi-Agency Policy and Procedures website which can be found here: http://www.llradultsafeguarding.co.uk

Information received for the purpose of safeguarding adults reviews must not be stored for longer than necessary and must not be used or shared in any way without the prior consent of the LSAB or one of its Sub-Groups.

7. Publication:

Following sign off of the safeguarding adults review Executive Summary, Overview Report and Action Plan, it will be the responsibility of the main LSAB Board to determine publication of the review. There is no requirement for a SAB to publish a safeguarding adults review that it has commissioned. However, statutory guidance does identify that, '*In the interest of transparency and disseminating learning the SAB should consider publishing the reports within the legal parameters about confidentiality*[2]'. As such, consideration will need to be given to the specific details of each review and whether publication is approved, on a case by case basis.

Options for publication include but are not limited to, publishing on the LSAB website or sharing with the National SAR Library. Where publication is agreed, the Review Sub Group Chair will

[2] Department of Health (2017). Care and support statutory guidance
[online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[Accessed 31 August 2018].

chair SAR publication meetings as required, with meetings being supported by the LSAB Board Office.

It will be important to note that the Care Act 2014 Schedule 2 mandates that as soon as is feasible after the end of each financial year, an SAB mush publish a report on what it has done during that year, including:
(d) the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
(e) the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
(f) what it has done during that year to implement the findings of reviews arranged by it under that section, and
(g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

8. Parallel Processes:

Where there are parallel processes or reviews, Statutory Guidance should be taken into consideration as follows:

'Links with other reviews

14.174 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (for example, because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs 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.

14.175 In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SCR or DHR, a criminal investigation or an inquest.

14.176 It may be helpful when running a SAR and DHR or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. 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.'

Locally, as soon as it is recognised that a SAR may be run in parallel with another review (for example an SCR, a Learning Disability Mortality Review (LeDeR) or a DHR), the LSAB Board Manager will make contact with the relevant bodies running the other review/s in order minimise avoidable duplication. This is likely to involve arranging a joint meeting to establish at the outset how the SAR process will dovetail into any other review running parallel.

9. Lessons Identified & Lessons Learnt

Single agency actions developed in response to single agency IMR recommendations, will be monitored by the Review Sub Group to ensure that they are achieved.

Single and/or multi-agency actions developed in response to Overview Report recommendations will also be monitored by the Review Sub Group to ensure that they are achieved.

Upon all the actions from a review being complete, the Review Sub Group will refer the review to the Performance Sub Group with a request that assurance is sought that the completed actions have made a difference in practice and that learning has been embedded i.e. assurance that lessons identified have indeed been learnt. Where it is found not to be the case, remedial action will be taken.

10. Sharing learning

In line with the LSAB Training Strategy, once a SAR has been completed and signed off at Board, the Review Sub Group will refer the review to the Training Sub Group:

- *The Review Subgroup will refer in any **multi-agency** training related recommendations from Safeguarding Adults Reviews (SARs) to the Training subgroup for action. It will be the responsibility of the training subgroup to action these recommendations by commissioning multi-agency training. The Training Subgroup will provide feedback of outcomes to the Review Subgroup who will then sign them off as complete.*

- *Each partner will be responsible for sharing the learning from SARs within their own agency. The Training Subgroup will be responsible for collating assurance that this has been completed.*

- *In addition, awareness-raising from SARs will be facilitated to staff by the Training Subgroup through a variety of methods i.e. conferences, multi-agency workshops, briefing papers, presentations at relevant meetings. Opportunities for collaboration across Leicester, Leicestershire and Rutland as well as the rest of the East Midlands region will be sought as appropriate.*

- *Awareness-raising from SARs in relation to the local community, service users, carers and families will be co-ordinated by the Engagement Subgroup. Opportunities will be sought for collaboration between the Training subgroup and Engagement subgroup.*

Appendix 1 – SAR Referral Form

Safeguarding Adults Review (SAR) - Referral to Review Sub Group

To make a referral please complete this form and sent to lsab@leicester.gcsx.gov.uk
You will receive e-mail confirmation of receipt of your referral within 5 working days

1. Details of person making referral

Name	
Position	
Agency	
Address	
Phone Number	
E-mail	
Referral Date	

2. Details of adult with care and support needs

Name	
Date of birth	
Date of death (if applicable)	
Address	
Care and support needs / significant medical information	

3. Please provide a brief outline of the incident

4. Please outline the factors that suggest the SAR criteria are met
44 Safeguarding adults reviews **(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –** **(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and** **(b) condition 1 or 2 is met.** **(2) Condition 1 is met if –** **(a) the adult has died, and** **(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)** **(3) Condition 2 is met if –** **(a) the adult is still alive, and** **(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect** Please state how in this case there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult:

Please confirm whether Condition 1 or 2 is met in this case and provide details:
Has Condition 1 been met? YES/NO
Has Condition 2 been met? YES/NO
It is requested that the Review Sub Group discuss the SAR criteria above and jointly decide whether or not the criteria for a SAR or any other alternative review are met.

5. Please list the agencies/service providers known to be involved in this case

6. Please provide brief detail any other proceedings or investigations that you are aware of relating to this case

7. Review Method

LSAB must determine locally the process for undertaking SARs. No one model is prescribed. If a decision is made to proceed with a SAR in this case, which review method/s do you think would be most appropriate?

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

Action Learning Approach This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

Peer review approach A peer review approach encompasses a review by one or more people who know the area of business. Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

Thematic Reviews A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or investigation. A thematic review considers an individual case as a starting point, but looks at issues raised generally, rather than the details specific to the case.

Other please state

No strong opinion at the time of referral

Appendix 2 – Review Sub Group SAR Recommendation to LSAB Independent Chair Form

Details of individual/s concerned

Name	
Date of Birth	
Date of death (if applicable)	
Address	
Trawl period	

Review dates

Referral date	
Date presented to Review Sub Group	
Trawl sent	
Trawl deadline for responses	
Board Manager Report	
SAR criteria discussion at Review Sub Group	
Review Sub Group Chair Recommendation	
Recommendation put to Independent Chair	

Case Background & why a SAR was being considered

Review sub-group recommendation & reasoning

LSAB Independent Chair decision

Decision	
Comments	
Date	