Safeguarding is everybody's business

Policy Title	**Safeguarding Adults Review Procedure**
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Responsible Manager	
Ratified By	
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Responsible Group	**Safeguarding Adults Review Group**

Safeguarding Adults Review Procedure

Information sheet

Please note that the internet version of this document is the only version that is maintained. Therefore, any printed versions should be viewed as 'uncontrollable' and may not be the most up to date

This document will be made available in different formats upon request. Please contact:

MSAR Learning & Review Officer

Email sar@wirral.gov.uk

Contents

Merseyside Safeguarding Adults Review Group

Safeguarding Adults Review Procedure

1 Introduction and Purpose

Section 44 of the **Care Act 2014** requires that a Safeguarding Adults Board (SAB) to arrange for there to be a Safeguarding Adults Review (SAR) when an adult in its area

with needs for care and support (whether or not the local authority area has been meeting those needs if: …

there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, ***and***

- *the adult has died,* ***and***

- *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)* ***or,***

- *the adult is still alive and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.'* ***or,***

- *the adult is still alive and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.'*

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).

Purpose

The purpose of a SAR is to identify where agencies could have worked together more effectively to protect the adult with care and support needs and identify lessons which can be learnt to reduce repetition and prevent harm occurring again. A SAR is NOT about proportionating blame

2 Scope

The Merseyside SAR Group will consider, all SAR referrals submitted, to establish if the concern meets the above criteria and will subsequently make recommendation to the relevant SAB Chair.

The SAR Group may also make recommendation to the relevant SAB Chair that, whilst the referral fails to meet S44 the case may provide useful insights into the way that organisations are working together to prevent and reduce abuse and neglect of adults with care and support needs. Further review of the case may also provide opportunity to explore examples of good practice where this likely to identify lessons that can be applied to future cases.

3 Information Sharing

S45 of the Care Act 2014 creates a legal **duty** for any agency or person to share what they know with the Safeguarding Adults Board (SAB). The Merseyside SAR Group will be undertaking this function on behalf of the four LA area Boards. Requested information must be for the purpose of enabling or assisting decision making and to ensure every opportunity is taken to embed learning across the partnership and beyond.

4 Referral

Any person or agency may make a referral to the SAR Group where they consider that the circumstances causing the concern meets the above criteria (See Point 1). The referral form can be accessed via local websites or via the MSARG Officer at sar@wirral.gov.uk and once completed should be sent to sar@wirral.gov.uk

Submission must be promptly confirmed through a telephone call to the SAR Learning & Review Officer: **0151 443 5644**

Referrals should be made promptly to avoid loss of learning; therefore, cases will not be submitted to the SAR Group where 2 years have passed since the incident, except in extenuating circumstances. One example would be where there have been criminal proceedings.

5 Merseyside Safeguarding Adult Review Group

The Group will meet monthly. The SAR Learning & Review Officer will prepare the Agenda and Case Information from all relevant parties to enable informed decision making. In order to optimise discussion all partners must prioritise requests for information and submit information within the agreed timescales.
It is expected that all referrals received in the previous 6 weeks will be listed for discussion and consideration. In the event of failure to list, the Learning & Review Officer will advise the relevant SAB Board Manager. Updates on existing SAR Panels will be a standard item on the Agenda. The relevant key representative within the group will present the referral and the rationale behind submission. The Learning & Review Officer will deliver a formal report from other agencies not represented at the meeting.

The SAR Learning & Review Officer will send SAR recommendations signed by the Merseyside SAR Group Chair, to the relevant SAB Chair for consideration. The relevant SAB Chair will then notify the Learning & Review Officer of the final decision to accept/ decline the recommendation and advise what actions will be undertaken by the Board. In circumstances where a SAR recommendation is accepted the Learning & Review Officer will lead on the commissioning of the Author and Chair of the SAR Panel and establish the SAR Panel.

In the event of a disagreement with the SAR Group recommendation the relevant SAB Chair will, in writing, inform the SAR Group Chair of the rationale behind their decision to disagree. Arrangements to meet will be agreed, without delay, to further discuss the decision.

In the event of a recommendation where S44 criteria is not met but alternative methods of learning are advised, the SAR Group will expect to receive feedback and Action Plans from the relevant LA area Board on how learning is optimised across the partnership.

6 Parallel Investigations and Reviews

Consideration should be given to any other investigation or review that may be concerned with the same circumstances. If there has been a sudden and unexpected death the relevant Coroner may have requested or directed an investigation to take place, see guidance here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283937/coroner-investigations-a-short-guide.pdf

If the circumstances concern domestic abuse, a Domestic Homicide Review (DHR) may be required, see guidance here https://www.gov.uk/government/collections/domestic-homicide-review

Learning from Life and Death Reviews (LeDeR) is the first national programme of its kind aimed at making improvements to the lives of people with learning disabilities. Reviews are being carried out with a view to improve the standard and quality of care for people with learning disabilities and autistic people LeDeR - Home

Parallel processes will be considered prior to a SAR Panel being established and appropriate guidance from agencies / services will be followed. This could lead to a delay in the SAR and if this is the case, relevant agencies, family will be notified.

It might also lead to joined up reviews for example a SAR may be joined with DHR, LeDeR or a Serious Case Review (SCR) if the criteria for both is met. If this is the case the most appropriate person to liaise with the family will be identified from the Panel.

There are also links with Mental Health Homicide (MHH) Reviews and again where the criteria are met terms of reference will be requested for the Merseyside SAR Group to make an informed decision on whether a SAR is needed.

If there is an ongoing police investigation into an incident direction from the police authority will be sought.

To reduce duplication of enquiries consideration will be given to the most appropriate form of review to ensure all learning is extracted and cascaded across the partnership. In some cases, a review may be commissioned jointly to reduce replication of work for the organisations involved.

7 Pre- SAR Panel

The Individual and/or their Family - Early consideration will be given as how to best consult and involve the adult, who is subject of the review (if applicable), together with their family and carers, in the review, in line with the principles of '**Making Safeguarding Personal**'. They may be able to make valuable contributions to the review. The Learning & Review Officer is responsible for liaison with the family throughout the review. Leaflets for families involved in the SAR process or other type of Learning Review are available from the Learning & Review Officer and on local board websites / webpages

Advocacy - The Care Act 2014 requires that, should the adult subject to a SAR have a '*substantial difficulty*' in being involved in the SAR process, then **the relevant local authority must appoint an independent advocate to represent and support an adult** where they have no other suitable person to represent and support them. The Learning & Review Officer will liaise with the relevant local authority to arrange an independent advocate if one is required.

Author – an Independent Author will be appointed. They may be from within the partnership or commissioned externally through the NEPO commissioning platform. This person will have the appropriate knowledge, skills and experience to undertake the writing of the Overview Report and will have had no prior involvement with the case.

SAR group/SAR Panel Meetings -

Chronologies/Timelines –Chronologies/timelines will be collated by the Learning & Review Officer and sent to members of the SAR Panel (including the Author) prior to the initial meeting.

8 SAR Panel

The SAR Panel will oversee the review in the local area and will meet to take forward the Overview Report which the Independent Author will be writing. The role of the members of the SAR Panel is to provide information as requested, to ensure attendance at review meetings, to provide points of clarification if needed. They will be managers without direct line management responsibility for the case and without previous involvement in the matter.

Panel members will be people with the ability and seniority to effect real change in their organisation and to influence others in the SAR Panel to effect change across the Partnership. Panel members need to be able to identify any gaps in the Panel membership of agencies that have a key role but are not yet represented. Panel members will commit to participation in Panel, considering the preparation and times of meetings and affording them priority.

The SAR Panel will be quorate when health, police (if required) and local authority representatives are present, together with the Chair and Independent Author. The SAR Panel will meet on average between 3-7 times.

9 Methodologies

Possible methodologies for the SAR Panel are set out below and explained more fully within the SAR Toolkit. This list is not exhaustive. The methodology will be recommended by the SAR subgroup and ratified by the Chair of the local SAB. There are a number of different methodologies the SAR Group may use one or a hybrid of methodologies depending on the facts of the referral. Below is an overview of methodologies.

Para. 14.170 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. The recommendations and action plans from a SAR need to be followed through by the SAB.

Traditional process – A Panel will be selected in the relevant area and an Independent Chair and Independent Author are appointed to lead the process. Initially agencies will be asked to produce chronologies of their involved with the person. Following this Individual Management Reports (IMR) will be completed by each agency outlining involvements and key issues. An Overview Report will be produced containing analysis, lessons learnt and recommendations. From this a combined action plan will be produced for all agencies involved.

The Welsh Model – in this process an Author independent of the case management lead the SAR Panel. Initially information is gathered on agency timelines with a critical analysis of significant events. A merged timeline is then produced. There is also a Genogram for the family. This is circulated to the SAR Panel and Authors analyse and identify hypothesis and learning issues to be explored. There is then a multiagency learning event which engages the frontline professionals who were known to the family, SAR Panel and Author. Following the multi-agency learning event the Author

drafts the Overview Report and Action Plan, this is then presented to the SAR Panel for discussion before the final draft goes to the Safeguarding Adults Board.

SCIE – Action Learning – this is a reflective/active learning approach which seeks areas of good practice and identifies areas for improvement. This is achieved by a collaborative partnership, including those involved at the time in the joint identification and deconstruction of the serious incident, its context and recommended developments. A Reviewer is appointed as well as the Overview Author. Relevant evidence is reviewed against guidance and a summary of events and key issues are provided by relevant agencies. This is then circulated to the SAR Panel and there is a 'learning event' to consider what happened and why, areas for improvements, areas of practice and lessons to be learnt. The Overview Report is then produced and there may be a follow up meeting to consider action plan recommendations.

Significant Incident Learning Process – as above but with slight variance

Multi-Agency Review – led by the relevant local authority for the area, the criteria for a SAR may not have been met but learning opportunities may have been identified. The action plan will be shared with the SAR group.

Single Agency Review – The local SAB should be informed of any Single Agency Review with a significant safeguarding or learning element. This is for the Board to consider any transferable learning across the partnership. This does not mean that all reviews are notifiable to the Board and each agency within the partnership has its only discretion in relation to the notification to the Board.

10 Communication & Media

SAB member organisations will publicise within their own agencies the criteria and circumstances under which a SAR may be considered and the process under which a referral might be made. This information will also be publicly accessible.

No member agency should comment publicly upon the case without express agreement of both their senior management, MSAR subgroup Chair and the relevant SAB Chair.

The Chair of the SAR Panel in consultation with the Independent Author, Chair of the SAR Group, Local Board Manager and relevant local partners will consider appropriate publication on a case-by-case basis. Discussions about publication will be held with individuals and their family or carers (where appropriate).

Since the Local Authority is the lead agency, media and communication issues will usually be led by the relevant authority's Communications Team. This will be done in collaboration with Communication Teams of the other agencies involved, alongside the relevant local SAB Chair and Board Manager.

11 Implementing the SAR recommendations

Any immediate practicable actions identified within the SAR process that could be implemented, should be implemented before the action plan has been written, this should be referenced in the Overview Report.

The Overview Report will include an action plan which reflects the agreed and endorsed recommendations of the report. The action plan will be Specific, Measurable, Achievable, Realistic and Timebound (SMART). This will be presented by the Author to the relevant local SAB for discussion and agreement. Any amendments will go back to the SAR group and be agreed, the report returning to the local SAB when the suggested amendments have been made for final sign off.

The SAB Chair, Board Manager and SAR group Chair to consider the format and implications of the publication of the SAR report in line with the Care Act 2014. They should also consider any associated Media and/or Communication Strategy.

Each agency is responsible for implementing relevant recommendations contained in their action plans within the timescales agreed and their local Board.

The implementation of the action plan will be monitored by the local SAB once the action plan has been fully embedded, the Executive Summary of the Overview Report and action plan will again be presented to the SAB to report on completion of the plan.

The Local SAB owns the contents of the SAR Overview Report and Learning

Reviews undertaken on behalf of their Board. Information will be shared with families in relation to the Overview Report, however individual information provided by agencies remains their property, and will be shared in accordance with their policies and procedures.

12 SAB Annual Report

The local SABs Annual Reports will contain a summary of SAR referrals received and SARs undertaken over the course of the previous year together with learning points.

13 Complaints

Should an individual or their family wish to make a complaint about the conduct of a SAR or the decision not to conduct a SAR, they should be directed to send their complaint to the Learning & Review Officer (in the first instance (Stage 1). This will then be discussed with the SAB Board Manager for the relevant area. The Board Manager along with a member(s) of the SAB who have not been involved in the process so far will meet to discuss. Hopefully most concerns/complaints can be resolved at this point. A written response will be made within 40 working days. If there is a delay the complainant will be informed of the reason and be provided with a date when they will have a written response to their complaint.

If the person making the complaint is not satisfied, they can then raise a Stage 2 complaint to the SAB Board Manager. This will be discussed with the local SAB Chair and the Chair of the SAR group. A written response will be provided to the complainant within 40 days of receipt.

Stage 3, anyone may appeal their complaint to the Local Government and Social Care Ombudsman. At the conclusion of any investigation the Ombudsman will publish the outcome and rational for their decision on their website:

http://www.lgo.org.uk/adult-social-care

Any professional with a concern should refer to the SAB Escalation Policy for their area.

14 Appendix – Jargon Buster

Safeguarding Adults Board	SAB
Safeguarding Adults Review	SAR
Learning & Review Officer	LRO

SAR group	SARG
Senior Investigation Officer	SIO
Crown Prosecution Service	CPS