**Torbay & Devon Safeguarding Adults Partnership (TDSAP)**

**Multi-Agency**

**Safeguarding Adults Review (SAR)**

**Policy**

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# **Introduction**

* 1. Safeguarding Adults Reviews (SARs) are complex, detailed and lengthy reviews, undertaken for the purpose of understanding and learning from individual cases to continuously improve the effectiveness of the wider system. They are reserved for situations where there is potential for extensive systemic learning due to serious questions about the multi-agency system as a whole.
  2. Safeguarding Adults Reviews are commissioned and managed by the Torbay & Devon Safeguarding Adults Partnership (TDSAP) and are only undertaken in circumstances involving the death or serious injury or harm of a vulnerable adult or adults known to numerous agencies when it is believed that the death was caused by abuse or neglect or that abuse or neglect contributed to the death or serious injury.
  3. Section 43 of the Care Act requires every Local Authority to establish a Safeguarding Adults Board (SAB) for its area. The SAB operates at a strategic level, helping and protecting adults in its area from abuse and neglect through co-ordinating and reviewing a multi-agency approach across all member organisations. The Torbay & Devon Safeguarding Adults Partnership (TDSAP) is the collective name for the partners that work together to safeguard adults across Torbay and Devon
  4. 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. SARs can also be arranged in any other situations involving an adult in its area with needs for care and support.
  5. This Policy aims to inform and assist the TDSAP SAR Core Group and their colleagues in fulfilling their legal duty to undertake SARs on behalf of the TDSAP.

# **Criteria for a Safeguarding Adults Review**

* 1. The TDSAP has a legal duty within s.44 of The Care Act 2014 to arrange a safeguarding adult review when
* 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
* 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).

*(Care Act 2014 s.44(1)(2))*

* Safeguarding Adults Boards may also 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).

*(Care Act 2014 s.44(4))*

2.2 The SAB should be primarily concerned with weighing up what type of ‘review’ process or methodology will 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.

2.3 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.

2.4 All SARs are statutory; the distinction to be drawn is between reviews that are mandatory and those that are discretionary. It is important that the legal mandate is made clear.

2.5 The Care Act is supported by the Care and Support Statutory Guidance which sets out the procedures that the TDSAP should have in place to ensure compliance.

# **Principles & Purpose of a Safeguarding Adults Review**

3.1 The Policy outlined in this document reflects and builds on the six safeguarding principles outlined in the Government’s Statement on Adult Safeguarding published in May 2013. These not only should be the basis upon which judgements are made about events and practice but also are the principles underpinning the review process itself.

3.2 These principles are:

|  |  |
| --- | --- |
| ***Principle*** | ***What this means in practice*** |
| ***Empowerment*** | People being supported and encouraged to make their own decisions and informed consent |
| ***Prevention*** | It is better to take action before harm occurs |
| ***Proportionality*** | Proportionate and the least intrusive responses appropriate to the risk presented |
| ***Protection*** | Support and representation for those in greatest need |
| ***Partnership*** | Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting abuse and neglect |
| **A*ccountability*** | Accountability and transparency in delivering safeguarding |

3.3 The following additional guiding principles should also be applied by the TDSAP and all partner organisations to all reviews:

* The Safeguarding Adults Review should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.
* The adult who is the subject of any SAR need not have been in receipt of care and support services for the TDSAP to arrange a review in relation to them.
* Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
* All agencies involved in the case should be fully engaged in the Safeguarding Adults Review process and have the opportunity to contribute their views.
* The central focus of the Safeguarding Adults Review will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working.
* The Safeguarding Adults Review process should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew or could reasonably have been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.
* A Safeguarding Adults Review is not a disciplinary process and should be conducted in a manner which facilitates learning and allows for reflection.
* Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a Safeguarding Adults Review.
* 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 promote good practice;
* Agreed Terms of Reference for any SAR they arrange and these should be published and openly available. When undertaking SARs, the records should either be anonymised through redaction or consent should be sought.
* 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; and
* This Policy recognises that there are other forms of statutory reviews such as Domestic Homicide Reviews (DHR), Mental Health Homicide Reviews (MHHR), Coronial Inquests, Multi Agency Public Protection Arrangements (MAPPA) reviews and Children’s Serious Case Reviews (SCR) and the importance of managing the interface between these.

3.4 The process for undertaking SAR’s should be determined locally according to the specific individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, and remedial action and it may also provide further information 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 TDSAP and appropriate sub-groups.

3.5 TDSAP should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and/ or their family. In some cases, it may also be helpful to communicate with the person who caused the abuse or neglect.

3.6 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 and extensive professional knowledge.
* Inclined to promote an open, reflective learning culture

3.7 The purpose of conducting a Safeguarding Adults Review is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk. The Safeguarding Adults Review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary.

3.8 Specifically, the purpose of the Safeguarding Adults Review is to:

* Determine what might have been done differently to prevent the harm or death;
* Identify lessons and apply these to future cases to prevent similar harm again;
* Review the effectiveness of multi-agency safeguarding arrangements and procedures;
* Inform and improve future practice and partnership working;
* Improve practice by acting on learning (developing best practice) and
* Highlight any good practice identified.

3.9 Its purpose is 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

3.10 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

3.11 The TDSAP has produced a leaflet for families which may be used to provide further information about the SAR and its process.

# **Making a referral for a Safeguarding Adults Review to the Safeguarding Adults Review Core group**

4.1 This section outlines the process for making a referral. Following an incident, active consideration should be made as to whether or not a referral for a Safeguarding Adults Review is necessary. To support this, organisations should consider including an appropriate trigger question on internal incident reporting, investigation and /or review templates.

4.2 The following considerations should be made when deciding whether to make a referral for a Safeguarding Adults Review:

* The concerns must relate to a person with care and support needs – whether or not they are in receipt of services.
* Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.
* There are concerns about systemic failings relating to multiple organisations and so there is potential to identify ways to improve multi-agency practice and partnership working.

4.3 Some cases referred may overlap with other statutory review processes. In these circumstances, the Chairs of the respective review processes and Partnerships or Partnerships will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

4.4 There may also be parallel processes in place such as a criminal investigation or Coroner’s Inquest, which whilst not preventing a referral being made, will need to be taken account of in terms of the timing and management of any subsequent multi-agency review.

4.5 The family should be informed of the concerns and that a Safeguarding Adult Review referral is planned and so providing an opportunity for them to give their view about the referral and to discuss how they might want to be involved.

4.6 To make a referral for consideration of a Safeguarding Adults Review, a referral form (Appendix 1) should be completed and forwarded to the Torbay & Devon Safeguarding Adults Partnership Office via email to [safeguardingadultsboardsecure-mailbox@devon.gov.uk](mailto:safeguardingadultsboardsecure-mailbox@devon.gov.uk). Anyone can make a referral and if assistance is needed to complete the form, please email the above mailbox in the first instance and the TDSAP Office will be happy to assist.

## **5. Decision making – Safeguarding Adults Review Core Group**

5.1 All SAR referrals are initially considered by the SAR Core Group (SARCG) which reports to the TDSAP.

5.2 The TDSAP has delegated the authority for reviewing and screening SAR referrals to the SAR Core Group who will, after consideration make recommendations to the TDSAP Chair for full consideration by the Partnership as to whether or not to proceed with a SAR.

5.3 The SAR Core Group is made up of statutory TDSAP members and multi-agency partners or a representative from their organisation.

5.4 The referrer of the case for consideration of a SAR or another appropriate person may be invited to the meeting when it is considering their case, to give further information to inform the sub group’s considerations.

* 1. The SAR Core Group Chair will decide, in conjunction with SARCG members, if Appendix 2s are needed for a referral. The SARCG will confirm the agencies, organisations or professionals who should contribute to the SAR through a request for further information (Appendix 2). The purpose of the Appendix 2 is to gain an overview of events and changes in an adult's life, including any relevant information regarding their wider family including any children they parent or care for. The Appendix 2 is designed to give more information than just the Appendix 1, which can then assist with effective decision making on whether the referral meets the criteria for a SAR. In some cases Appendix 2’s may not be required, e.g. where another report provides the relevant information.

5.6 The Chair of the SAR Core Group will inform the referrer of the decision, in writing.

5.7 The SAR Core Group will monitor and progress the process of completion of the SAR.

5.8 The SAR Core group will also consider findings from Root Cause Analysis (RCA), Serious Incidents Review Investigation (SIRI), Domestic Homicide Review (DHR), Mental Health Homicide Reviews (MHHR) and other statutory, internal or independent management reviews.

5.9 The TDSAP will disseminate agreed learning to Partners and sub-groups to inform training and learning opportunities. The TDSAP is required to undertake this as directed by the Care Act.

# **Key Questions for SAR Core Group to consider when a decision is being made to recommend whether a SAR takes place**

6.1 The SAR Core Group needs to ensure that the following questions have all been addressed before a recommendation to undertake a SAR is made to the TDSAP:

* 1. How might family members be involved both to gain further background information on the case and to be kept informed of SAR progress and outcomes?
  2. What information needs to be obtained following review of the Appendix 1 (Appendix 2’s, SI reports, Port-Mortem reports)
  3. Are there any details (chronology/case background) missing from the Appendix 2s, or other relevant reports, received that would provide any further important detail to the case?
  4. Is there any more information required to provide further detail that had not yet been requested?
  5. Is there strong evidence of Multi-agency involvement in the case?
  6. Are there any other circumstances around the person’s death that require further investigation?

# **Procedure for commissioning and completing a Safeguarding Adults Review**

7.1 The SAR Core Group will consider the appropriate and proportionate review methodology and output for the case.

7.2 In the event that the decision is to commission an independent review, the SAR Core Group will need to draft Terms of Reference for consideration by the TDSAP, which scope out the required tasks and the projected potential costs. Determining how the costs of the SAR will be met will not delay the commencement of the SAR. The Terms of Reference will also be considered for further adaptation or amendment once the Reviewer is appointed

7.3 Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with needs of care and support. If the SAB requests relevant information from a body or person (for example, in the context of a Safeguarding Adults Review) then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB. The test is that the information requested by the SAB must be for the purpose of enabling or assisting the Partnership to perform its functions of which carrying out Safeguarding Adults Reviews forms part.

# **Safeguarding Adults Review methodologies**

8.1 No single model or methodology is prescribed for SARs. The choice of approach for each SAR is significant as how a review is conducted and will influence the learning; and whether the process is constructive and educative for those involved (SCIE 2015).

**8.2 Safeguarding Adults Reviews methodology options**

8.2.1 Social Care Institute for Excellence (SCIE), Health and Social Care Advisory Service (HASCAS)

The model outlined by SCIE has 3 methodology options for conducting Safeguarding Adults Reviews, from which local Safeguarding Adults Partnerships can decide upon the most appropriate in each case.

An overview of methodology/process, level of flexibility and relative benefits in relation to each review is outlined below and to help inform local decision making.

**(i) Option One – traditional SCR approach**

In this option the SCR methodology is reflected in most local protocols and follows a traditional model, broadly:

* Appointment of SCR panel, including Chair (usually independent) and core membership-which determines terms of reference and oversees process
* Independent report author (overview report, summary report)
* Involved agencies produce Individual Management Reports (IMRs), outlining involvement and key issues and;
* Chronologies of events
* Overview report with analysis, lessons learnt and recommendations
* Relevant agencies produce action plans in response to the lessons learnt
* Formal reporting to the Safeguarding Adults Partnership and monitoring implementation across partnerships

This more traditional SCR methodology is more likely to be deemed applicable where there are demonstrably serious concerns about the conduct of several agencies (which will be considered following the initial review of the Appendix 2s or inter-agency working and the case is likely to highlight national lessons about safeguarding practice or where he issues of concern have been subject to previous review/inspection criticism.

**Advantages and disadvantages of review approach**

The relative merits and drawbacks of this SCR methodology are outlined below.

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| familiar to SAB/stakeholders, who may consider it more robust/objective | Overly bureaucratic |
| Where public/political confidence may only be assuaged via a tried and tested approach | Protracted-implementation of lessons learnt/recommendations not sufficiently responsive to time considerations |
| Where there is multiple abuse, or high profile cases/serious incidents | Costly-costs |
| Methodology usually reflects that of Children SCRs/Domestic Homicide Reviews (DHR) | Often deemed punitive, attributing blame |
| Frontline staff often precluded, so disengagement from process and subsequent learning |

Where other statutory reviews, such as a child SCRs or Domestic Homicide Reviews(DHR) overlap with an adult safeguarding review, consideration should be given to the most appropriate methodology to achieve joint outcomes and avoid duplications of process (see also 5 below).

**(ii) Option Two – Action learning approach**

This option is characterised by reflective/action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

* Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person’s history); specific areas of focus/exploration
* Appointment of facilitator and overview report author
* Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies
* Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
* Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
* Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
* Event to consider first draft of the overview report and action plan
* Final overview report presented to Safeguarding Adults Partnership, agree dissemination of learning, monitoring of implementation
* Follow up event to consider action plan recommendations
* Ongoing monitoring via the Safeguarding Adults Partnership

Further variance

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documentation review, staff interviews and report production.

The table in Appendix 1 is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the Independent Chair of the Safeguarding Adults Partnership (see 11.3) in consideration of the best fit and individual preferences in the light of the case in question.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

* Social Care Institute for Excellence (SCIE)-Learning Together Model
* Health and Social Care Advisory Service (HASCAS)
* Paul Tudor-Significant Incident Learning Process

Although embodying slight variations, all of the above models are underpinned by action learning principles. (See Appendix 2 for contact details). There will undoubtedly also be considerable expertise within London partnerships which could be deployed to facilitate action learning SCRs.

**Advantages and disadvantages of review approach**

The relative merits and drawbacks of this review approach are outlined below.

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| Significant evidence approach is much more efficient | Methodology less familiar to many |
| Swiftness of conclusion and embedding the learning |
| Considerable reduction in overall costs compared to more traditional approaches |
| Action learning approach enhances:  • partnership working  • mutual recognition of alternative partner perspectives  • collaborative problem solving |
| Involvement of both frontline staff/senior managers secures both strategic and operational perspectives |
| Unique perspective of staff involved in the case, reflective of the systems operating at the time |
| Approach allows for identification of system strengths/positive practice |
| Learning take place through the process and there is enhanced commitment to its dissemination |

**(iii) Option Three – Peer review approach**

This option is characterised by peer reviews and accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, (for instance a Safeguarding Adults Partnership members), or other agencies within the region.

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this SCR option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the Safeguarding Adults Review.

The appointed peer team/panel should agree the Terms of Reference and specific methodology with the Safeguarding Adults Partnership.

Advantages and disadvantages of review approach

The relative merits and drawbacks of this review approach are outlined below:

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| Objective, independent perspective to particular case/aspects of safeguarding practice | Capacity issues within partner agencies may restrict:  • availability  • responsiveness |
| Usually via trusted sources sharing common experiences/understanding | where political or high profile cases deems local oversight is preferable |
| Can be part of reciprocal arrangements across/between partnerships | Potential for allegations of collusion between agencies if no tangible recommendations made |
| Very cost effective, usually no fees incurred |

8.2.2 Other Examples (not exhaustive) of learning models which may be considered are:

**The SCIE learning together model**

The Learning Together approach has been used in both safeguarding adults and safeguarding children’s reviews. The model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture. Practitioners are part of the case review team, their perspectives are used to inform all aspects of the Review, including lessons learned.

**SILP (Significant Incident Learning Process)**

This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a ‘Learning Event’ and ‘Recall Session’.

**Root Cause Analysis (RCA)**

RCA has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

**Appreciative Inquiry (AI)**

This approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change. SARs conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements

8.3 The Independent Chair of the Torbay & Devon Safeguarding Adults Partnership will determine the methodology in consultation with the Chair of the SAR Core Group.

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# **9. Timeliness for completion of a Safeguarding Adults Review**

9.1 The SAB should aim for completion of a SAR within a reasonable period of time and in any event within six 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 or a very complex review. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action. It will be appropriate where family members and or friends of the person are involved to keep them updated on progress

# **Findings from Safeguarding Adults Reviews**

10.1 The SAB should include the findings from any SAR in its Annual Report along with the actions it has taken or intends to take in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation the SAB receives from registered providers which is relevant to CQC’s regulatory functions will be given to the CQC on CQC’s request.

10.2 SAR reports should provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence. The report should be written in plain English and contain findings of practical value to organisations and professionals. 

# **Publication and Media communication**

11.1 Communication and publication will be managed within and across agencies by the SAB and will be published on the TDSAP website: <https://www.devonsafeguardingadultspartnership.org.uk/>

# **Further Reading & Acronyms**

Torbay & Devon Safeguarding Adults Partnership

<https://www.devonsafeguardingadultspartnership.org.uk/about/safeguarding-adult-reviews/>

Domestic Homicide Reviews.

<https://www.gov.uk/government/publications/domestic-homicide-report-guide>

Safeguarding Adults Review under the Care Act: implementation support (SCIE) <http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/files/safeguarding-adults-reviews-under-the-care-act-implementation-support.pdf>

Sharing Information

<http://www.scie.org.uk/care-act-2014/safeguarding-adults/sharing-information/>

User involvement in Safeguarding

<http://www.scie.org.uk/publications/reports/report47/>

Care and Support Statutory Guidance

<https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016>

**E-learning Resources**

Safeguarding Adults under the Care Act

<http://www.scie.org.uk/publications/elearning/adultsafeguarding/>

Mental Capacity Act

<http://www.scie.org.uk/mca/e-learning/>

**Acronyms**

CQC Care Quality Commission

DHR Domestic Homicide Review

MAPPA Multi-Agency Public Protection Arrangements

NHS National Health Service

RCA Root Cause Analysis

SAB Safeguarding Adults Partnership

SAR Safeguarding Adults Reviews

SCR Serious Case Reviews (children)

SI Serious Incident

TDSAP Torbay & Devon Safeguarding Adults Partnership

# **Appendix A Roles and responsibilities of the Safeguarding Adults Review Panel.**

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| **ROLE AND RESPONSIBILITIES OF THE SAFEGUARDING ADULTS REVIEW PANEL** |

1. **Confirming the scope of the Safeguarding Adults Review**

The SAR Panel should review the Terms of Reference with the Lead Reviewer, in the

light of the facts available, in each case. Relevant issues to include:

* Confirm the time period to be reviewed – how far back should enquiries cover?
* Determine the methodology for the SAR
* Agree how and when family members will be informed or involved, and who will make initial contact with them.
* Are there features of the case which indicate the SAR should be conducted by an independent person not associated with any of the involved agencies or organisations?
* Is there a need to inform another Safeguarding Adults Partnership that the SAR involves organisations and agencies in their area?
* How will organisations and agencies outside of the area be approached?
* Is there a need to liaise with the Coroner’s office or the Crown Prosecution Service?
* Does the Panel need to consider any other parallel processes to reduce the impact of duplication (domestic homicide review, Serious incident, mental health or suicide review, LeDeR)?
* How will public and media interest be managed?
* Does the SAB / Panel need legal advice to consider any aspect of the SAR?

1. **Analysis and examination of chronology / Appendix 2s / other agency reports and documentation**

Individual agency reports and chronologies are provided for the purpose of producing an Overview Report which is published and can be accessed by the family, public and media.

The information contained in the APPENDIX 2’s, other agency reports and documentation should not be published without the consent of the report provider (who may have to seek the consent of the individual professionals who provided the information).

The full consideration of the factual and analytical components of the APPENDIX 2 and is a key task of the SAR Panel. If there are concerns about insufficient information or the quality of analysis in these reports, then the matter should be urgently referred back to the respective agency to ensure it is rectified.

At the final stage of drafting the Overview Report, the report should be shared with the authors involved in preparing the APPENDIX 2’s, reports and other documentation, to check for factual accuracy.

1. **Producing the Overview Report**

Suggested format for an Overview Report, although details may need to change depending on the nature of the case.

* Introduction
  + Summary of circumstances leading to the SAR
  + Terms of Reference
  + List of contributors to the SAR, Panel members, Author of the Overview Report.
* Facts
  + Acknowledgement of and reference to any issues relating to disability or ethnic/religious diversity
  + Integrated chronology of involvement with the adult at risk by all relevant professionals, noting each occasion when the adult at risk was seen and the views or wishes sought or expressed by the adult at risk.
* Analysis
  + Reflect the Terms of Reference
  + A consideration of how and why events occurred
  + How decisions were made and actions taken, or not
  + Comment as to whether, in the Panel’s view, different decisions or actions may have led to an alternative course of events
  + Highlight examples of good practice
* Conclusion and Recommendations
  + Summary of the lessons learnt form the SAR
  + Consider any trends which are reflected locally or nationally
  + Recommendations should include, but not limited to, recommendations made in APPENDIX 2’s or individual agency reports
  + Recommendations need to be few in number, achievable, focused and specific
* Executive Summary
  + Should contain:
    - a précis of the SAR process
    - Case details
    - Key findings
    - Recommendations
  + Details of the victim cannot be identified unless details are already in the public domain
  + Made available to the Public

1. **The Role of the Safeguarding Adults Partnership**

The safeguarding adult partnership should approve the overview report and executive summary after presentation at the partnership meeting

* Presenting the Overview Report / Executive Summary to the TDSAP
  + Overview Report to be ‘signed off’ by the SAR Panel
  + Reports to be forwarded to the TDSAP Independent Chair
  + Independent Chair decides to whom copies of the report will be circulated
  + Full (and final Draft) Report presented to the TDSAP for approval
* Approving the Report:
  + Partnership members to familiarise themselves with the Report and prepare any questions for the agenda item
  + Brief overview of the content of the Report and findings presented by the Chair of the SAR Core Group to the TDSAP
  + Go through the recommendations in detail, highlighting implications for practice, to enable the organisation and / or the relevant sub group to develop a detailed action plan and timetable for completion.
  + Decision on distribution list of the overview report and / or Executive Summary as appropriate
  + Arrangements for dissemination of lessons learnt
  + Arrangements for feedback of lessons learnt to contributors (organisations and professionals) to the Overview Report
  + Arrangements for feedback to family
  + Arrangements for media interest – preparation of media statement
  + If implementation of the recommendations cannot be resolved by the TDSAP there may need to be discussions between the Independent Chair, CQC and the organisation(s) affected
* Publication
  + Independent Chair to agree the publication date
  + The Overview Report will be circulated to the Chief Officers of all the relevant agencies highlighting the recommendations for their individual organisation and asking them to ensure implementation within their own agency
  + Independent Chair to ensure a copy of the Executive Summary and action plan is sent to CQC
  + Independent Chair to consider and agree if the Overview Report and/or Executive Summary needs to be shared with the Coroner’s office, Crown Prosecution Service or any other party

1. **The Role of the Safeguarding Adults Review Core group**

The SAR Core Group will be responsible for overseeing the first draft of the Action Plan.

The SAR Core Group will approach organisations for regular updates and assurance that the action plan is being fully implemented and to highlight any issues or delays to the TDSAP. The SAR Core Group will confirm the appropriateness of outcomes recorded by agencies to meet actions.

The SAR Core Group will provide regular reports to the TDSAP (and other relevant sub groups) on the progress with the implementation of the recommendations.

# **Appendix B SAR Process Map**



# **Appendix C Interface with other proceedings or investigations.**

|  |
| --- |
| **INTERFACE WITH OTHER PROCEEDINGS OR INVESTIGATIONS** |

Some Safeguarding Adults Reviews may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, multi-agency public protection arrangements or a children’s serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible. The following section outlines the legal context for other statutory reviews:

**Child Practice Reviews** *-* Regulation 5 of the Local Safeguarding Children Partnerships Regulations 2006 requires Local Safeguarding Children Partnerships to undertake Child Ptractice Reviews where:

(a) Abuse or neglect of a child is known or suspected AND

(b) Either the child has died;

**OR**

1. The child has been seriously harmed

**AND**

b) There is cause for concern as to the way in which the authority, their Partnership partners or other relevant persons have worked together to safeguard a child.

**Domestic Homicide Reviews -** Domestic Homicide Reviews were established on a statutorybasis in April 2011 under section 9 of the Domestic Violence, Crime and Victims Act2004. Domestic Homicide Reviews are carried out into the circumstances in which thedeath of a person aged 16 or over has, or appears to have, resulted from violence, abuseor neglect by:

(a) A person to whom he or she was related or with whom he was or had been in an intimate personal relationship

(b) A member of the same household as him or herself, held with a view to identifying the lessons to be learned from the death.

**Multi Agency Public Protection Arrangements -** The guidance published in 2012 regarding Multi-Agency Public Protection Arrangements (MAPPA) reviews states that these should be undertaken when the mandatory criteria have been met if both of the following conditions apply:

1. The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed

**AND**

b) The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

Discretionary MAPPA Safeguarding Adults Reviews are also permissible. It is difficult to prescribe discretionary criteria, as much will depend on the circumstances of the particular case, and whether there has been a significant breach of the MAPPA Guidance, but MAPPA Safeguarding Adults Reviews might be commissioned when:

a) A level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape

**OR**

1. An offender being managed at any level is charged with a serious offence listed in PI 10/2011 – (Appendix 6 of MAPPA Guidance);

**OR**

c) It would otherwise be in the public interest to undertake a review, e.g. following an offence which results in serious physical or psychological harm to a child or vulnerable adult but which is not an offence listed in PI 10/2011.

**Mental Health Homicide Reviews -** In June 2005 the Department of Health issued guidance on the NHS responsibility to commission independent investigations of serious incidents in mental health settings (HSG (94) 27). The responsibility for the management of these reviews now rests with NHS England. The criteria for a mental health review are:

(a) When a homicide has been committed by a person who is, or has been, under the care, that is subject to regular or enhanced care programme approach, of a specialist mental health service in the last six months prior to the event.

(b) When it is necessary to comply with the State’s obligation under Article 2 of the European Convention on Human Rights whenever the State agent is, or may be, responsible for a death or where the victim sustains life threatening injuries.

(c) Where serious patient safety incidents warrant an independent investigation, for example, if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

**Criminal Investigations -** There may be a criminal investigation running concurrently with the Safeguarding Adults Review. In these situations, the criminal investigation takes precedence, although this should not delay the work being undertaken in respect of the Safeguarding Adults Review.

Any possible witnesses should be interviewed first by the police as part of any criminal proceedings before being interviewed for the purposes of their agency’s individual management review (APPENDIX 2). It may also be necessary to delay the publishing of overview reports until the conclusion of any criminal trial. Single agencies can however progress with implementing the learning from individual APPENDIX 2s.

**Individual Organisational Reviews -** It is also acknowledged that all agencies will have their own internal / statutory procedure to investigate serious incidents. This policy is not intended to duplicate or replace these and any opportunities to prevent duplication will be encouraged. In some cases, dependent on the specific issues in the case, internal investigation reports may provide adequate information to address the terms of reference or it may be that additional reports are required to address any outstanding areas. Careful planning and communication is required to make the most effective use of resources and avoid duplication. It may be necessary for the SAB to request information and/or reports arising from other statutory reviews to inform the Safeguarding Adults Review process.

Any such requests will be made under section 45 of the Care Act 2014 as outlined in paragraph 5.3 of this document.

# **Appendix D Safeguarding Adults Review Referral Form (Appendix 1)**

**Safeguarding Adult Review (SAR) Referral Form (Appendix 1)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referral details** | | | | | | |
| Safeguarding Adults Board/Partnership | | |  | | | |
| Date of referral to SAR Subgroup | | |  | | | |
| Name of referrer | | |  | | | |
| Job title | | |  | | | |
| Agency | | |  | | | |
| Address | | |  | | | |
| Telephone number | | |  | | | |
| Email address | | |  | | | |
| **Adult’s details** | | | | | | |
| Adults Name | | |  | | | |
| Any known other names | | |  | | | |
| Date of Birth | | |  | | | |
| Address | | |  | | | |
| Telephone number | | |  | | | |
| Email address | | |  | | | |
| Name of Nearest Relative/Next of Kin | | |  | | | |
| Address | | |  | | | |
| Telephone number | | |  | | | |
| Email address | | |  | | | |
| **Agencies known to be involved** | | | | | | |
| *Service* | | | *Details* | | | |
| Care/Nursing Provider/Home | | |  | | | |
| District General Hospital | | |  | | | |
| NHS Provider | | |  | | | |
| Mental Health Services | | |  | | | |
| Community Nursing | | |  | | | |
| General Practitioner | | |  | | | |
| Domiciliary Provider | | |  | | | |
| Community Interest Company | | |  | | | |
| Local Authority Adult Social Care | | |  | | | |
| Local Authority Children Social Care | | |  | | | |
| Police | | |  | | | |
| Probation | | |  | | | |
| Housing Services | | |  | | | |
| Drug and Alcohol services | | |  | | | |
| CQC | | |  | | | |
| SWAST | | |  | | | |
| Other Service(s) (please specify) | | |  | | | |
| **Reason for the referral**  *Please identify the basis on which you are making this referral using the relevant legislation* | | | | | | |
| ***Care Act 2014 Section 44 Safeguarding Adults Reviews****This section has no associated Explanatory Notes*  *(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if -*  *(a) there is reasonable cause for concern about how the SAB, members of it or 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.*  *(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).*  *(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to -*  *(a) identifying the lessons to be learnt from the adult’s case, and*  *(b) applying those lessons to future cases.* | | | | | | |
| **Characteristics of the referral (Y/N)** | | | | | | |
| Domestic abuse |  | Alcohol/substance use | |  | Discrimination |  |
| Mental health |  | Death in custody | |  | Honour based violence |  |
| Sexual abuse |  | Suicide | |  | Modern slavery |  |
| Psychological abuse |  | Self-harm | |  | Hate/mate crime |  |
| Physical abuse |  | Organisation abuse | |  | Mental capacity |  |
| Self-neglect |  | Neglect/acts of omission | |  | Serious illness |  |
| Are there other related processes ongoing or planned? i.e. criminal proceedings, ombudsman investigations, professional conduct enquiries | | |  | | | |
| **Referral summary**  *Please**provide a summary of the circumstances that have led to this referral* | | | | | | |
|  | | | | | | |
| **Involvement**  *Please outline the communication that has taken place with the individual concerned, their family and/or friends regarding this referral and their views. Please give contact details of the people involved.* | | | | | | |
|  | | | | | | |

**Please return this completed form to** [**safeguardingadultsboardsecure-mailbox@devon.gov.uk**](mailto:safeguardingadultsboardsecure-mailbox@devon.gov.uk)

# **Appendix E Single Agency Summary Report (Appendix 2) Form**

**Safeguarding Adult Review (SAR) - Single Agency Summary Report (Appendix 2)**

**RESTRICTED**

**STRICTLY PRIVATE AND CONFIDENTIAL – NOT FOR DISCLOSURE**

**TDSAP CASE REF: XXXX (SAR Admin only)**

|  |  |
| --- | --- |
| **Adult’s details** | |
| Name |  |
| Date of birth |  |
| Address |  |
| Incident Date |  |
| **Involvement with agency / service**  *Please identify your agency’s involvement with the adult in the twelve months leading up to the incident. Please also include any additional information outside of that timeframe where appropriate.* | |
|  | |
| From what date does your agency hold records for this person |  |
| **Immediate learning**  *Please identify any immediate areas of learning for your agency and include details of how such learning will be addressed.* | |
|  | |
| **Sharing information**  *The review report will usually be shared with the person concerned or family members involved. Please provide details of any information within this report that cannot be shared with the person concerned or family members involved and the reason why.* | |
|  | |
| **Agency details** | |
| Agency |  |
| Name of person completing this summary report |  |
| Job title |  |
| Address |  |
| Email |  |
| Telephone number |  |
| Date |  |

**Please return completed summary to**[**safeguardingadultsboardsecure-mailbox@devon.gov.uk**](mailto:safeguardingadultsboardsecure-mailbox@devon.gov.uk)**by XXXX**

# **Appendix F Completing Single Agency Summary Reports (Appendix 2s) Guidance**

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| --- |
| **Completing Appendix 2s** |

It is important to fully complete all sections of the form.

The letter making the request will state the timescales that information from your organisation is being sought, and a deadline for the information to be returned to the SAB office.

The purpose of the Appendix 2 is to gain an overview of events and changes in an adult's life, including any relevant information regarding their wider family including any children they parent or care for.

**Client details-** This will be pre-filled upon issuing the letter for requesting Appendix 2s

**Involvement with agency / service**

This is the information about an incident, event, visit and will include anything that is done by your agency including inter/intra agency communication or contact e.g. contacts requesting information. This section MUST include brief chronology of all decisions made relating to the person, summaries of the decisions made and actions taken, how the subject presented and services offered and identify if the wishes/feelings of the subject were sought and recorded, the author should also note where there is no record. This should include clear analysis and their involvement with the person (both positive and negative assessments) and actions taken. Authors should not assume another agency will include an event/contact in their Appendix 2, if it is identified in records it should be included.

**Immediate learning:**This is informationabout any immediate areas of learning identified by the agency based on the information that they know. This section MUST either include assurance that the agency is taking action to address any immediate learning identified or should specify that on the information that they know there are no immediate areas of learning.

**Sharing information:**The review report will usually be shared with the person concerned or family members involved. This section should include details of any information within the report that cannot be shared with the person concerned or family members involved. The should include the agencies rationale for why this information cannot be shared.

**Agency Details-** please complete in full

**Appendix G Safeguarding Adults Review and Overview Reports**

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| **SAFEGUARDING ADULTS REVIEW AND OVERVIEW REPORTS – TOP TIPS FOR REVIEWERS** |

**1. Be clear about the purpose of the report and process**

The purpose of the Review is to help to build improvements. This should be achieved by identifying any problems that occurred and any examples of good practice. Then agreeing with the service(s) or organisation(s) what can be done to address the problems and learn from good practice.

The enquiry into what happened and how the case was managed is only part of the Review process. There should always be a focus on helping to achieve the outcome of building improvements. This requires clear analysis and practical recommendations.

**2. Work with the people affected and, in the services, involved.**

You need to have independence and objectivity but involvement and partnership with the people affected and people who are likely to be making improvements at every level is also important.

Provide clear information to the people involved and provide them with an opportunity to comment and provide feedback.

There should be agreement through the Safeguarding Adults Review panel on who will lead on involving any service users, family members or carers.

**3. Structure the report clearly and link it to the terms of reference.**

For Overview reports there may be some variation in the structure depending on the case and Terms of Reference, but the following should all be included in some way:

* Introduction of author – who are you
* Introduction (short case history)
* Chronology, as appendix
* Information on the case, what happened and role and actions of the service(s) involved.
* Analysis, including any relevant interagency working issues
* Conclusions, learning and recommendations
* Number each paragraph

**4. Succinct report writing takes time and provides the best results**

Less is more, shorter messages are stronger.

Concise reports and summaries can take longer to write but are more likely to be read. Short sentences are usually easier to read and take in. Some details and references can be included in appendices.

**5. Be careful with language and remember your audience.**

Don’t use ‘agency’ jargon and explain abbreviations.

**6. Be proportionate and evidence your analysis and judgements**

If you use professional judgement or opinion, particularly about other services or people from other professions back it up with reasons and facts.

Strong wording can help to give impact to the report but make sure you have a full enough understanding of the role, context and rules within which the people and services involved operate. If you are not sure it is better to ask or raise questions for others to respond to.

**7. Draw on relevant research as well as the facts of the case**

Use information from your enquiries and other relevant research to back up findings and recommendations, including any relevant local and national policy, procedures, guidance and best practice.

**8. Include any changes and improvements that have already been made**

Include any positive practice, policy and procedure changes that have been made since the events being reviewed took place.

**9. Consider how professionals saw things, felt and thought at time.**

Put things in context. Including some comments from professionals involved and comments from records made at the time can help to illustrate key points about practice, culture and judgments at the time. This can help identify learning which may be needed.

**10. Avoid outcome bias**

Outcome bias is when we judge a past decision by its outcome instead of judging it on what was known or could be expected at that time.

**11. Make a limited number of clear, specific, achievable recommendations.**

Where possible recommendations should be ones where measurable progress and evidence of impact is likely to be possible. However not everything that is important is measurable and not everything that is measurable is important.

Less is more for conclusions and recommendations. While some challenges need multiple actions to address them, it can be helpful to focus on providing a small number of major conclusions and recommendations. Chose ones that you judge to be most important and are likely to have the biggest positive impact.