Sandwell Safeguarding Adults Board

SSAB@SSAdultsBoard

Sandwell Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW PROCESS

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Introduction

Safeguarding Adults Reviews (SARs)

The Care Act 2014 introduced statutory Safeguarding Adult's Reviews (previously known as Serious Case Reviews), and mandates when they must be arranged. The act also gives Safeguarding Adult Boards (SABs) flexibility to choose a proportionate methodology.

The prime purpose of a Safeguarding Adult Review is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of adults with care and support needs.

Sandwell Safeguarding Adult's Board (SSAB) extends its appreciation to the West Midlands Adult Safeguarding SAR Guidance which is referenced throughout this document.

Safeguarding Adults Boards must arrange a SAR when:

An adult* in its area dies of abuse or neglect, whether known or suspected. AND there is concern that partner agencies could have worked more effectively to protect the adult. They must also arrange a SAR if:

An adult* in its area has not died, but the SAB knows or suspects that the adult has experienced serious** abuse or neglect AND there is concern that partner agencies could have worked more effectively to protect the adult.

They may also commission a SAR in other circumstances where it feels it would be useful, including learning from "near misses" and situations where the arrangements worked especially well.

*Adult must be ordinarily resident in the SABs area and have needs for care and support (whether or not the local authority has been meeting any of those needs). ** 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.

The purpose of this guidance is to provide individuals and organisations with a local framework for the initiating and conducting of Safeguarding Adult Reviews; and a range of good practice tools and exemplars for those involved in managing the process to ensure reviews are carried out effectively and in a consistent manner.

As such, Sandwell Safeguarding Adult's Board (SSAB) will arrange a SAR when an adult in its area who has needs for care and support, dies or sustains serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

SSAB is committed to ensuring that SARs are undertaken for the clear purposes of driving positive change and improvement in practice, rather than as a punitive or accusatory process.

2. The Purpose and Principles

A SAR is not an enquiry into the cause of an individual death or injury, it is not an investigation of culpability and is completely different to any investigation undertaken by police, a coroner, or regulatory bodies such as Care Quality Commission (CQC).

SARs should seek to determine what lessons can be learned from the case and how local relevant agencies worked together, ensuring learning is applied in practice to prevent similar harm from occurring again.

Safeguarding Adult Reviews should be conducted in a way which:

a) Recognises the complex circumstances in which professionals work together to safeguard adults with care and support needs.

b) Seeks to understand precisely what led agencies or individuals to act as they did and when they did.

c) Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.

d) Is transparent about the way data is collected and analysed.

If adults are to be protected from the likelihood of neglect or abuse or neglect in the future, individuals and organisations need to be able to learn lessons from the past. The SAR process needs to encourage honesty, transparency and the sharing of information, for maximum benefit. As such, Sandwell SAB will seek to ensure that SARs are undertaken for the sole purpose of evoking positive change and improvement in practice and that lessons learned are disseminated effectively and timely.

There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults. Professionals/ practitioners should be involved fully in any SAR and invited to contribute their perspectives. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

The individual (where applicable) and their families should be invited to contribute to any SAR review. They should be helped to understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Where appropriate, arrangements should be made for an advocate or other support. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 (39D) then, unless inappropriate, the same advocate should be used. It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process. Involvement of the individual and family provides an opportunity for personal perspective, and aids professionals to understand the adult's lived experience, personality and identity; as well as an insight into family life and professional encounters. Family narratives about services is unique and dynamic; and minimises assumptions being made solely on case records or agency records.

Involvement of the individual and family provides the opportunity to:

a) Obtain a person perspective: providing professionals with the opportunity to understand the adults lived experience and a sense of the adult's personality and identity.

b) Obtain an insight into family life and professional encounters: family narratives about services is unique and dynamic; and minimises assumptions being made solely on case records or agency records.

c) Assist the individual and family members (individually and collectively) to cope with their feelings and the aftermath of an adult dying or suffering a serious injury.

A SAR should also offer an opportunity to assist the individual and family members (individually and collectively) to cope with their feelings and the aftermath of an adult dying or suffering a serious injury.

The Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practice.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the teams / staff whose actions are being reviewed.

The West Midlands Adult Safeguarding SAR Guidance makes clear that it is only by publishing SAR reports that organisations will demonstrate to the public the level of transparency and accountability needed to enable lessons to be learned as widely and thoroughly as possible. This should ensure professionals are able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

3. Referral of cases for a Safeguarding Adults Review

Any individual (including members of the public), may request consideration of a SAR, by completing SSAB's referral form. A staff member in a partner organisation should discuss their concerns in relation to the case in question within the management structure of their own organisation before submitting the request for a SAR. The completed referral needs to explain why it is felt that the threshold for a SAR has been met, and the referral then sent to our secure email:

SSAB_Team@sandwell.gcsx.gov.uk or secure email by arrangement.

Please also call **0121 569 5790** to alert us that a referral has been sent or to talk to us if you do not have a secure email address that you can send the email from.

Once received by SSAB, the Lead Officer for Protection will arrange for the case to be discussed at the next available Protection Sub Group; where it will be considered by partners against the criteria. In some cases, the referrer will be asked to provide further details for consideration. Where a degree of urgency has been identified, an Extra Ordinary Protection Sub Group meeting may be called to consider the referral. Wherever possible, the referrer or most appropriate person will be invited to attend the Protection Sub Group meeting to present the information in person. If the sub-group decides that SAR criteria is not met, they will consider whether an alternative review or process should be undertaken, (e.g. Serious Incident or Management Review within an agency).

To be quorate, the Protection Sub Group making this decision must always contain at least one representative from the local authority, the police, and a Health Partner. Other relevant partners should also be invited to attend or contribute, depending on the nature of the case.

After consideration, the recommendation from the group will either be:

a) the case is dealt with as a SAR, or

b) the criteria are not met and the issues are best addressed through other routes.

This recommendation will normally be made on the basis of a majority opinion. In the event of disagreement however, any member of the group can take their concerns to the SSAB Chair to seek resolution. In any event, the chair of the SSAB will be the final decision maker subject to recommendations from the Sub-Group.

A member of the public may make a complaint to the Local Government Ombudsman if dissatisfied with the response from the Chair of SSAB.

For every case referred for consideration, a written record of the rationale for the decision will be maintained, via meeting minutes and the SAR referral database.

4. Immediate Actions

In the event of a SAR request being accepted, the Chair of the sub-group will:

- notify the Chair of SSAB, the referring agency and all constituent agencies
- notify all board members that a SAR has been accepted
- set up a SAR panel, with appropriate membership dependent upon type of case referred, and appoint an independent Chair/Author
- organise for records, from agencies involved to be secured
- where applicable, notify the victim and/or their family as appropriate
- inform the Care Quality Commission as appropriate
- notify other Safeguarding Boards who have an interest in the case that Sandwell is conducting an SAR
- if the decision is not to proceed to an SAR, the referrer should be notified by the Chair of the Sub-Group, stating the reasons.

5. The SAR Panel

The SAR Panel, will consist of members of the Protection Sub-group and will need to:

a) Agree arrangements for informing the relatives of the adult at the centre of the review, of the decision to initiate a SAR and ensure appropriate support.

b) Agree arrangements for timescale and communication strategies.

c) Agree arrangements for learning outcomes on the basis of recommendations.

All such decisions and actions, including those that are taken by a SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability).

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

a) strong leadership and ability to motivate others;

b) expert facilitation skills, an ability to handle multiple perspectives and potentially sensitive and complex group dynamics;

c) collaborative problem solving experience and knowledge of participative approaches;

d) good analytical skills and ability to manage qualitative data

e) safeguarding knowledge; and ability to promote an open, reflective learning culture. There is a statutory duty for agencies as requested to co-operate in the SAR process. Where difficulties are experienced and cannot be resolved in a timely manner, the SAR Panel will formally escalate the issue to the Chair of SSAB for resolution.

The time taken to conduct the SAR should be within a reasonable period but no longer than 6 months, though this may be extended by agreement with the Chair of the Sub Group (who will liaise with the SAB Chair) if the case is unusually complex or if there are other mitigating factors (e.g. it would prejudice court proceedings).

6. Methodology

The process for undertaking SARs should be determined locally according to the specific circumstances of individual situations. Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options. No one model or methodology will be applicable for all cases, the SAB will need to weigh up what type of 'review' process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

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 following methodologies are taken from the West Midlands Adult Safeguarding SAR guidance and regional guidance, no approach should be seen as holding more importance or value than another. In circumstances where the SAR criteria are not met these methodologies could still be used to aid learning and improve outcomes for adults.

a) 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. This model includes

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning
- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

The benefits of this model are:

- is likely to be familiar to partners
- possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- methodology stems from children's arena so process to adults is not so familiar
- resource intensive
- costly
- can sometimes be perceived as punitive and
- does not always facilitate frontline practitioner input.

b) 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. 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. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity. 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)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles. 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 prevailing 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 Board, agree dissemination of learning, monitoring of implementation
- follow up event to consider action plan recommendations
- ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- conclusions can be realised quicker and embedded in learning
- cost effective
- enhances partnership working and collaborative problem solving
- encompasses frontline staff involvement
- learning takes place through the process enhancing learning.

The drawbacks of this model are:

- methodology less familiar to many
- events require effective facilitation
- specific versions such as SCIE Learning Together and SILP are copyrighted

c) Individual Agency Review

This model would be relevant when a serious incident or near miss identifies just one agency being involved or one agency who may need to learn from the situation and there are no implications or concerns regarding involvement of other agencies.

Such reviews undertaken under the SAR process should always be instigated and scrutinised by the SAB. Additionally, any recommendations should be considered by the SAB who should produce and monitor a Board action plan as a result of the review to ensure any transferable learning is shared across the partnership.

Circumstances when this model might be appropriate:

- serious Incidents
- implications relate to an individual agency but lessons could be shared, applied and learnt across the partnership
- where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

The benefits of this model are:

- provides an opportunity for learning from a individual agency
- enables individual agency scrutiny into a specific area
- assists in implementing 'Duty of Candour'
- cost effective and proportionate

The drawbacks of this model are:

- can be seen as outside the SAR purpose of multi agency learning
- individual agency opposition.

d) Peer review approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasingly used within Adult Social Care.

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.

There are a variety of models for peer review:

- peers can be identified from Safeguarding Adults Board members
- peers could be sourced from another area/SAB which could be developed as part of regional, reciprocal arrangements

The benefits of this model are:

- increased learning and ownership if peers are from the SAB
- objective, transparent ,independent perspective
- can be part of reciprocal arrangements across/between partnerships
- cost effective and proportionate

The drawbacks of this model are:

- capacity issues within partner agencies may restrict availability and responsiveness
- skill and experience issues if SARs are infrequent
- potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

e) Significant event analysis/audit

(SEA) SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it. NHS England has published Serious Incident Framework in March 2015 The benefits of this model are:

- it is not a new technique – doctors have long discussed cases for educational and professional purposes.
- cost effective and proportionate.

The drawbacks of this model are:

- Could be seen as a model that relates only to Health.

f) Case file audit (multi or single agency, table top or interactive)

Case file audit can be a powerful driver in improving the quality of front line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

- as a table-top exercise (therefore no input from practitioners)
- in liaison with the Regional Principal Social Work Network Interactive with partners and or practitioners
- interactive with the adult and or their family
- proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- flexible – in that they can be conducted in many different ways
- quicker learning can be achieved
- cost effective and proportionate

The drawbacks of this model are:

- there may be limited learning from sole examination of paper records.

g) Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors, the root causes of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA.

investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes
- to be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence
- there is usually more than one potential root cause of a problem
- to be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well know and frequently used in the NHS
- Focus is on the root cause and not on apportioning blame or fault
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

7. Duty of Candour

All members of a Safeguarding Adult's Board (SAB) are required to have a culture of openness, transparency and candour within their day to day work and with the SAB. In interpreting this 'duty of candour', we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice, as members of the SAB, all agencies have a responsibility to ensure they are open and transparent with the SAB when incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incidents that meet the criteria for a SAR.

The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns. Every agency has a responsibility for identifying both their own learning and multi-agency learning.

8. Links to other statutory review processes

There are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). These reviews may sometimes be relevant to a SAR (e.g. because they concern the same person thought to have caused harm, or because they meet the criteria for more than one review). Where this is the case, consideration will be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible.

Any SAR will also need to take account of a Coroner 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.

9. Production and publication of Safeguarding Adults Review reports

An overview report of findings will be produced for every SAR that is undertaken.

The final draft version of this report will be approved by the SAR Sub Group based on it meeting the following criteria:

a) Sound analysis of what happened and why, and is as concise and focused as possible;

b) The report will include an introduction, terms of reference, details of facts, analysis and specific and timely recommendations;

c) It is written in plain English; and contains findings of practical value to organisations and to persons who have contact with adults who have care and support needs.

d) The final version of the report will then be presented for approval to the Chair of the SSAB; Once ratified, an overview of the findings will be published on the BSAB website. Agencies will be asked to report back to board detailing what learning has taken place as a result of the recommendations in the report. Where appropriate an additional learning event will also be undertaken.

Sandwell Safeguarding Adults Board

SSAB@SSAdultsBoard

SAFEGUARDING ADULT REVIEW Referral Form

All requests will be assessed by the Board's Protection Sub Group and Vice Chair/Chair of the Board within six weeks. To be quorate, the SAR group making this decision must always contain at least one representative from the local authority, the police, and a local Clinical Commissioning Group (CCG) as statutory partners.

If the matter requires urgent attention, an extra ordinary meeting of the group may be convened to consider the request.

Please send requests to the secure email address: **ssab_team@sandwell.gcsx.gov.uk**

Sandwell Safeguarding Adults Board
Independent Living Centre 100 Oldbury Road, B66 1JE
T: **0121 569 5790**

REFERRER

Name and Job Title:

Organisation Name and Address:

Email/Tel:

Date:

DETAILS OF PERSON AT RISK WITH CARE AND SUPPORT NEEDS:

Name:

Address: (ordinarily resident in Sandwell?)

Date of Birth:

Date of Death/Serious Injury:

GP Contact Details:

Other household members or significant others:

Contact details of agencies involved with adult with care and support needs

Contact details of Next of Kin, Representative/Advocate

Where applicable, is the adult at risk aware of this referral? YES NO

Criteria for review – please consider how you feel the following criteria is met

1. Adult with care and support needs dies as a result of abuse or neglect, and where there is concern that partner agencies could have worked more effectively together to protect the adult.

1. Adult with care and support needs has sustained permanent harm or potentially life threatening injury as a result of the suspected abuse or neglect and where there is concern that partner agencies could have worked more effectively together to protect the adult.

2. Public interest issues such as multiple adults with care and support needs or from multiple perpetrators.

DETAILS OF INCIDENT AND REASONS FOR REQUEST (box will expand)

Have you or any other agency undertaken any incident review in relation to this case? Please describe:

Are any other adults in the living environment believed to be at risk of similar harm?

Document any other statutory processes in progress, e.g Operational Safeguarding, Child SCR Domestic Homicide Review, Mental Health Review

Detail how you believe the criteria (page 2) for SARs has been met

Evidence of concerns not acted upon?

Please add any other details as fully as possible

What were the key relevant points/opportunities for assessment and decision making?

Did the adult with care and support needs have the mental capacity to make the decisions relevant to this case? (in accordance with MCA 2005)

Was the adult subject to an unauthorised deprivation of liberty?

FOR OFFICE USE

Date Ref Received:

Ref complete or incomplete?

Date Taken to Protection Sub Group:

Decision Taken:

Reasons for Criteria not Being Met:

Reasons for Criteria Being Met:

Agreed Actions:

Date decision fed back to referrer

Sandwell Safeguarding Adults Board
Independent Living Centre, 100 Oldbury Road, B66 1JE
T: 0121 569 5790
sandwellsab.org.uk

Sandwell Safeguarding Adults Board
SSAB@SSAdultsBoard

Addressee
Address

Date

Dear Addressee

RE: Consideration of a Safeguarding Adults Review

Sandwell Safeguarding Adults Board (SSAB) is currently considering the circumstances of a recent death of an adult who has previously used your organisation's services.

This information will be collated and used by the Protection Sub Group and Chair of the board in order to form a decision as to whether a full multi-agency Safeguarding Adults Review (SAR), should be commissioned by the Sandwell Safeguarding Adults Board.

Depending on the level of interaction your organisation had with the individual, your agency may be required to complete an Internal Management Review and may be asked to nominate a representative to sit on the Safeguarding Adults Review Panel.

With this in mind, we would ask that you complete the attached scoping questions form and return securely by (two weeks from date of letter) to enable the Sub Group to ascertain if a SAR will be required.

Michelle Moore
Lead Officer Protection

Sandwell Safeguarding Adults Board
Independent Living Centre
100 Oldbury Road
Smethwick
B66 1JE
Tel: 0121 569 5791
Email: michelle_moore@sandwell.gov.uk
sandwellsab.org.uk

Who will see the Report?

While the report is being written, it will ordinarily be kept confidential to those people representing their organisations at the Sandwell Safeguarding Adults Board; or who have contributed to the review.

The final summary of the Report will be published and will set out the key findings and recommendations to highlight lessons learned. It will not give any personal details and will be available to anyone who wants to read it on our website.

How long will it take?

The Safeguarding Adults Review should normally be completed within six months of the original referral. Sometimes however, this timescale needs to be extended.

Safeguarding is everyone's business

Sandwell Safeguarding Adults Board
Independent Living Centre
100 Oldbury Road
Smethwick
B66 1JE
T: **0121 569 5790**
sandwellsab.org.uk

Sandwell Safeguarding Adults Board

SSAB@SSAdultsBoard

Sandwell Safeguarding Adult Review

Leaflet for Families

The Sandwell Safeguarding Adults Board brings together local organisations to support good safeguarding practice in Sandwell

What is Safeguarding Adults Review (SAR)?

The purpose of a Safeguarding Adults Review (SAR) is to consider whether or not the death or serious harm of an adult, or group of adults with care and support needs, could have been predicted or prevented. Safeguarding Adults Reviews are not enquiries into how an adult with care and support needs died or who is culpable; that is a matter for Coroners or Criminal Courts to determine, as appropriate.

A SAR looks at how local organisations worked together to look after the adult at risk. The SAR considers what was done, what lessons can be learned for the future and what changes may need to be made. A SAR may also be requested when learning around incidents involving 'near misses' may be in the public interest.

There are different ways in which a SAR can be done, but they all involve gathering as much information from as many sources as possible.

A really important part of undertaking a SAR is to ask individuals where possible, or their family members for opinions about what happened, and these views should be reflected in the final report.

Who will carry out the Safeguarding Adult Review (SAR)?

A panel of professionals from community and adult care services, health services, the Police and sometimes other organisations are led by an independent person (the 'Author'). They will meet to review reports from each organisation or agency which has worked with or provided services to the adult at risk or their family. The independent author will prepare a report. This report will say what outcomes have been learnt and make recommendations for further learning.

What will happen after the Report is finished?

The findings of the review are summarised in a report, normally published by the Sandwell Safeguarding Adults Board. It is, therefore, a public document. However, no individuals are named in it. A SAR will often find there have been lots of agencies involved in the person's life.

Sometimes the best way forward is to ask the people who were directly involved with the adult in question to sit round a table together, and discuss face-to-face what went on and what has been learned.

The Sandwell Safeguarding Adults Board will agree an action plan to make sure improvements are made to the way organisations work together to keep adults safe. Organisations involved will need to show what learning has taken place as a result of the SAR. This will ensure ongoing learning is agreed by all partners who may have been involved and who may be working to safeguard people with care and support needs in future.

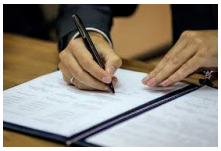
Sandwell **Safeguarding Adults** Board

SSAB@SSAdultsBoard

SAFEGUARDING ADULT REVIEWS

What is the Sandwell Safeguarding Adults Board?

It is a group of people who need to work together to try and keep local people safe from harm



What is a Safeguarding Adults Review (SAR)?

When a person who struggles to care for themselves without help either dies or is injured, we need to find out if this person had all of the help that they needed to keep safe.

We need to write a report about this so that everyone knows how important it is to work together to keep people safe.

How long will the Safeguarding Adults Review take and What Will Happen to it?

The report will take quite a long time because there are lots of people that need to help to write, It usually takes about 6 months.

Anyone will be able to read it to learn more about what lessons have been learned. But the report wont have anyone's name in it.

Is There Any Other Help Available?

If someone needs help to understand how to protect themselves, things will be explained in a way that is easy to understand.

Addressee
Address

Sandwell Safeguarding Adults Board
SSAB@SSAdultsBoard

Date

Dear Addressee

As you may be aware Sandwell Safeguarding Adults Board recently received a request from xxxx to consider a Safeguarding Adult Review (SAR) for the above named person.

My purpose in writing is to inform you that, the Adult Protection sub-group which operates under the governance of the Sandwell Safeguarding Adults Board, agreed that this request does meet the criteria for a SAR, and the chair of the board has agreed that this must be undertaken. Your agency is requested to undertake an Individual Management Review (IMR) accordingly.

An independent author called xxxx has been appointed, he/she will undertake appropriate investigation as defined by S44 of The Care Act, and will author the final report. Clearly, there are issues of confidentiality to be observed and no information will be shared in the public domain until matters have been dealt with. However, when the report is finalised this will be available as a public document.

It should be noted that Authors need to evidence independence of both practice and direct line management of staff involved, and should be able to attend a briefing meeting for authors on xxxx. At this meeting Terms of Reference will be discussed as well as specific areas for authors to consider when completing their IMRs. Templates and IMR guidance will also be issued.

The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. It is not about apportioning blame. The findings from the IMR will need to be quality assured and approved by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

The IMR will need to provide a chronology of agency involvement, bring together and draw overall conclusions from the practice of the agency in the care of xxxx

The IMR author should have access to supervision and be able to evidence, if requested, relevant training or experience to support their role as the IMR author. They should be able to:

- gather and analyse information,
- clearly describe what happened, commenting on the quality of practice
- provide explanations for what happened and why.
- clearly show how the conclusions relate to xxxx as well as the wider safeguarding practice within the organisation.

Accordingly, when considering the above information and briefing date, could you please confirm who will author and quality assure the IMR, and send confirmation of this by xxxx

Yours faithfully,

Michelle Moore
Lead Officer Protection

Sandwell Safeguarding Adults Board
Independent Living Centre
100 Oldbury Road
Smethwick
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Sandwell Safeguarding Adults Board

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IMR GUIDANCE

This is guidance to be read in conjunction with the notes included within the IMR template. Authors do not have to use these phrases, but the example questions set out rationale for an Individual management review report.

Authors need to evidence independence of both practice and direct line management of staff involved.

Methodologies

Please list sources of information used to compile your report here.

Authors should have already been provided with the Draft Terms of Reference if they are not available please contact The Board Manager at Sandwell Safeguarding Adults Board, Independent Living Centre, 100 Oldbury Road, Smethwick, B66 1JE, Tel 0121 569 5791.

Chronology

When completing the chronology, interviews with the professionals/staff/personnel involved, may be an integral part of the chronology and IMR report. Therefore, a record of the interview should be signed and agreed by the interviewer and the interviewee.

Making Safeguarding Personal

The adult's story/journey must take into consideration issues of race, culture, disability, gender and local context, as well as reference to the adult's ability to make specific decisions as defined in the Mental Capacity Act 2005; and where appropriate to Sandwell's self- neglect guidance (based on regional guidance)

Analysis

The author must review the information in the comprehensive chronology and produce a report. All abbreviations and acronyms should be fully explained. The report must consider how the services offered took account of the individual needs of the adult. Practice at individual and organisational levels must be openly and critically analysed against national and local statutory requirements, professional standards and current procedural guidance. Your analysis should reflect willingness by your agency to challenge practice and address wider agency responsibility. Good practice should be highlighted and areas for change in practice must be clearly identified. Where practice has changed from that detailed in the chronology, ie new service or revised procedures, this should be explained in the management report. Analysis must always relate to the terms of reference and the time period at the beginning of the document. Using these as headings may be a good way to construct your report.

Additional considerations to support analysis:

- Consider the events that occurred, the decisions made, actions taken and actions not taken. Where judgments were made or actions taken that indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.
- Consider specifically when and in what way were the adult's wishes and feelings heard and addressed? Was this information recorded? How was this responded to by your agency?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of adults with care and support needs? and acting on concerns about their welfare? If not, this needs to be addressed in your report. Were these adhered to? If not, why not? What were the key relevant points/opportunities for assessment and decision making? Do assessments and decisions appear to have been reached in an informed and professional way, considering mental capacity to make and execute decisions for example?
- Did actions accord with assessments and decisions made? What were the outcomes?

  Were appropriate services offered/provided or relevant enquiries made in the light of needs?

  Where no assessments were made, or actions taken the report needs to provide a rationale as to why this happened, and what alternatives were offered. Were senior managers or other organisations and professionals involved at points where they should have been?

  Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services.
- Were there any concerns about Persons in Positions of Trust (PiPoT)? Partner agencies and the service providers they commission are individually responsible for ensuring that information relating to PiPoT concerns are shared and escalated outside of their organisation in circumstances where this is required, proportionate and appropriate. They are responsible for making the judgment that this is the case in each instance where they are the data controller.

What Is The Learning?

The author should identify specific lessons which his/her agency can learn from. These can include areas of good practice identified, as well as ways in which practice can be improved. Are there implications for ways of working: training (single and multi-agency), management and supervision, working in partnership with other organisations, resources? Working across children and adult services.

Recommendations For Action plan

Individual agency recommendations for action contained in this report will be considered by the Protection Sub Group for inclusion in the final report. The Protection Sub Group may also recommend further actions for your agency to be included in the report. Any individual agency recommendations not included in the report are expected to be acted on within individual agency governance arrangements. Recommendations must be clearly outlined in the action plan in order to be clear about; What action should be taken, by whom, and by when? What outcomes should these actions bring about and how will the organisation evaluate whether they have been achieved.

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SAFEGUARDING ADULT REVIEW

Individual Management Report

This IMR will inform a multi-agency Serious Adult Review report, Its purpose is to look openly and honestly at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.

Person(s) this report relates to:	**Last known address:** **Date of birth:** **GP:**
Agency preparing this report:	
Report prepared by:	
Date of Report	

Key Findings / Methodologies Used / Chronology Identify facts, key decisions, sources of information and interviews

Terms of Reference (see separate Terms of reference)

Making Safeguarding Personal
The adult's story/ journey, relevance to MCA 2005 and/or self -neglect guidance, What are the equality and diversity issues?

Analysis
Did actions accord with assessments? Were decisions reached in an informed way?
Were concerns acted upon? Were there barriers to information sharing?
Any concerns about Persons in Positions of Trust (PiPoT?) Has practice changed?
What are the cultural, status or reputational issues that impacted here?

What lessons has this agency identified?
How can practice be improved? Are there implications for training and for working in partnership with other agencies? Are there lessons in how agencies could have communicated and shared information about the circumstances more effectively and whether this case raises any general concerns about difficulties in information sharing and communication.

Action Plan Recommendations for Your Agency What action should be taken, by whom and by when? What outcomes should these actions bring and how will this be evaluated? Are there any legal routes that could have been taken by any of the agencies that would have had an impact? Are there any policy gaps that impacted on this case or on the action taken by organisations and agencies involved? What recommendations specifically, would you suggest to improve inter-agency working and to better safeguard adults with care and support needs?

Any other comments

Signature of person completing this report:	
Date:	
Signature of Senior Manager:	
Date:	

Author Protection Sub Group
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Safeguarding Adults Review of (name)

TERMS OF REFERENCE

Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) 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.

(ii) 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).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Circumstances of Incident

Methodology

The Safeguarding Adults Review will primarily use an investigative, systems focus and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author or multi-agency Protection Sub-group to show comprehensive overview and alignment of actions.

Scope of Safeguarding Adult Review:

Adult: Date of Birth: Date of Death:

Timeframe

The scope of the SAR will be from to

Agency Reports

Agency Reports will be commissioned from (names of agencies):
Agencies will be expected to complete an IMR with chronology, template and guidance attached.

Any references to the adult, their family or individual members of staff must be in a consistent format, e.g by Initials, and for Professionals, identity such as Health Visitor - HV1 or Social Worker SW1.

Any reasons for none cooperation must be reported and explained, this also applies to timescales which should be strictly adhered to.

All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

Agencies will be asked to update WSAB on any actions identified in section 8 of the IMR prior to the completion of the SAR which will be fed into the final report. Updates will then be requested until all actions are completed.

Areas for consideration:

How the agency upheld Making Safeguarding Personal
How and when MCA and DoLS were applied and documented
How self- neglect guidance was applied
How multi-agency working was demonstrated at times of critical decision making

Parallel Process

E.G any Domestic Homicide Reviews or Crown Prosecution Service considerations?

Engagement with the individual/family

While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the individual/ family and details of their involvement with the SAR are included in this.

In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Sandwell Safeguarding Adults Board.

All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR.

Media Reporting

In the event of media interest all agencies are to use a standard no comment approach until the report is approved for publication.

Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Consideration should be given by all agencies involved in regards to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date

Administration

It is essential that all correspondence with identifiable information is sent via secure methods only.

Specific Questions for Agencies To Consider

It is essential that questions are documented unambiguously and specifically to each agency.

Timetable for Safeguarding Adult Review **DATE**

Scoping Meeting to agree on agencies to be involved, terms of reference, methodology etc.	
Letter to IMR agencies to identify authors and secure documents	
First introduction and discussion with the individual/family	
IMR Authors' briefing	
Completion date for IMRs	
Review of IMRs	
Draft report and recommendations circulated to Panel members	
Protection Sub Group	
Individual/ family	
Date for final amendments to draft report and recommendations	
Date for final report submission to board with all partners of SSAB -presented by author with recommendations	
Date for final report amendments and recommendations	
Date for final board ratification of report and recommendations	
Feedback to individual and /or family	
Date for Protection Group to determine multi-agency action plan from the SAR recommendations	
Date for learning events	
Date for publication on website	
Closure latter to individual and/or family	