Barnet Safeguarding Adult Board Safeguarding Adult Reviews

Safeguarding is everyone’s business.

Contents

1. Purpose and context of SARs

Under the Care Act 2014 (the Act), Safeguarding Adults Boards are responsible for arranging safeguarding adult reviews (SARs). The Act[1] requires each member of the safeguarding board to co-operate and contribute to the carrying out of a SAR with a view to:

- identifying the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases.

Barnet Safeguarding Adults Board ['Board' or 'SAB'] will maintain and develop this framework responding to local and national policies and changes in legal requirements.

Partner agencies and all local organisations who work with adults at risk are expected to endorse this Framework and embed it in their internal governance processes as well as workforce development policies. In addition, partner agencies and local organisations are responsible for:

- Providing staff and other resources to deliver the framework.
- Share information as required with those commissioned by the SAB to undertake the review to allow for an effective review.
- Contributing to reviews of practice undertaken by the SAB.
- Ensuring lessons learnt from these reviews of practice are disseminated widely within their organisation (e.g. internal training, policies/procedures, implementing actions plans).
- Ensuring that lessons learnt from these reviews of practice are embedded into practice (e.g. evaluation via auditing, staff surveys).

SARs are about learning lessons for the future. They provide an opportunity to improve multi-agency working, disseminate and embed learning as well as share best practice to better safeguard adults at risk of abuse or neglect.

The statutory guidance[2] states that Safeguarding Adults Boards should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This multi-agency framework endorsed by the Barnet Safeguarding Adults Board (SAB) provides a range of review mechanisms that could be utilised and the procedure to be followed where the statutory criteria for a SAR are met, or where it is agreed that a SAR should be initiated because the case could provide useful insights into the way organisations in Barnet are working together to prevent and reduce abuse and neglect of adults.

SARs arranged by the Safeguarding Adults Board (SAB) will seek to determine what the relevant agencies and individuals involved in the case might have

[1] Section 44(5)
[2] Care and Support Statutory Guidance (CASSG) issued under the Care Act 2014, p266

done differently that could have prevented harm or death. This will be based on information provided from across relevant agencies and wherever possible involving those affected, including family members, so that the SAB has a full picture of events.

To maximise learning and benefit from SARs, the process must be trusted, safe, and transparent and encourage honesty and sharing of information. The purpose is not to attribute blame to any individual or organisation. Whilst the SAB will conduct any enquiry mindful of obligations to refer concerns and disclosure duties, this process does not seek to replicate coronial duties, criminal proceedings, disciplinary procedures, or professional regulation.

2. When a SAR must be carried out

The criteria for initiating a safeguarding adult review are now established in statute. Section 44 of the Care Act requires Safeguarding Adults Board to 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 safeguarding adults board, members of it or other persons with relevant functions worked together to safeguard the adult, ***and***

(b) either condition 1 or 2 is met:

(i) Condition 1 is met if the adult has died, and the safeguarding adults' board 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).

(ii) Condition 2 is met if the adult is still alive, and the safeguarding adults' board knows or suspects that the adult has experienced serious abuse or neglect.

Serious abuse is defined [pg. 14.134 of Care Act Guidance] as arising where an adult would have died but for an intervention, has suffered permanent harm or reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. It should be noted that the harm can arise from omission where a partner agency had a duty to act to prevent harm

Where the criteria in section 44 are met, a safeguarding adult review **must** be carried out.

The SAB 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) where an adult at risk has experienced significant harm and/or abuse and the enquiries undertaken at operational level has identified any of the following:

- there were safeguarding concerns identified prior to the incident which required intervention from a member agency but were not be acted on in a timely or appropriate manner;
- one or more substantiated allegation is made in relation to an agency commissioned to provide in line with a statutory duty and the safeguarding team, commissioning body or regulatory authority have previously identified establishment concerns or made findings in relation to institutional abuse.

Nothing within this framework supersedes the obligation to alert the Safeguarding Adults team and/ or police if an adult is presently experiencing abuse or neglect or the responsibility to make enquiries in relation to alleged abuse or neglect of an adult at risk.

3. Key principles to be applied by the SAB and partner organisations

The statutory guidance [3] makes reference to six safeguarding principles applicable to all sectors and settings, which underpin all safeguarding work. These principles should be reflected in SARs and for ease of reference are set out below:

- **Empowerment** – people being supported and encouraged to make their own decisions and give informed consent.
- **Prevention** – it is better to take action before it occurs.
- **Proportionality** – the least intrusive response 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 neglect and abuse.
- **Accountability** and **transparency** in delivering safeguarding.

[3] Care and Support Statutory Guidance para 14.137, p267

As well as these six underpinning safeguarding principles, the statutory guidance sets out five principles that should be applied to all SARs by the SAB and all partner organisations:

- 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, identifying opportunities to draw on what works and promote good practice;

- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;

- 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;

- **professionals should be involved fully** in reviews and invited to contribute their perspectives **without fear of being blamed for actions they took in good faith**; and

- **Families and those directly affected should be invited to contribute to reviews**. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

The SAB adopts these underpinning principles to safeguarding and the five principles applicable to SARs. The SAB is committed to promoting a culture of continuous learning and improvement and positive reflection.

4. Identification and referral of cases for review

Any individual, agency or professional may refer a case where they believe the criteria in section 2 above have been met. The referrer should complete Form SAR1 (Appendix 1 of this document and also available on the SAB website). Form SAR1 sets out the statutory criteria and requires the referrer to explain how these are met. It also requires the referrer to explain the potential for learning for SAB, which supports the case for review. The completed SAR1 should be emailed to the SAB board manager at: from a secure address to the Safeguarding Adults Board.

5. Decision to arrange a SAR

Upon receipt of the referral the SAB Board Manager, if necessary in conjunction with the Chair of the Case Review Group Sub-Committee, will determine if

further information is required from other agencies and request a case summary (SAR2, Appendix 2 of this document) from the referrer and all relevant agencies of their involvement.

The collated information will be considered by the SAB's Case Review Group Sub-Committee to determine if the statutory criteria is met on the facts of the case and potential for learning it is deemed appropriate to arrange a SAR. Legal advice should be obtained as appropriate if there is uncertainty as to whether or not the statutory criteria are met. The decision should be recorded on Form SAR3 (Appendix 3 of this document).

Following consideration of the case summary and collated information, the Case Review Group will make a recommendation to the SAB and, if they believe the criteria is met, also advise on the most suitable *type* of review and the most constructive approach that would maximise learning from the review. A full decision will then be made by the SAB. Thereafter, the SAR sub-group will oversee the SAR process as detailed below and monitor the implementation of any recommendations arising from the review.

The SAB Board manager will inform the referrer of the decision and progress of the review and key milestones.

6. Type of review and role of Case Review Group or SAR Panel

The statute and guidance leave to SAB's discretion the type of review process that will best promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The type of review can only be determined according to the specific circumstances of individual cases and one model will not be appropriate for all cases. The schedule in Appendix 4 of this document sets out the different type of reviews that could be utilised for a SAR. This schedule is not an exhaustive list and the Case Review Group members will use their collective experience and knowledge to think about the rationale and recommend the most appropriate learning method based on the individual circumstances of the case being considered. The focus will be on what needs to happen to achieve understanding, remedial action, and where appropriate answers for families and friends of adults who have died or been seriously abused or neglected.

Where a decision to arrange a SAR is made, the SAB delegates to the Case Review Group or a core group of professionals from that group (the **SAR Panel**) the responsibility for scoping clear terms of reference, identifying key personnel and agencies, agreeing timescales, appointing the right facilitator or independent reviewer, tightly managing the process, considering learning events and liaising with the Learning and Development sub-group to ensure

learning is disseminated in the most appropriate way, embedded and the impact evaluated. Terms of reference should be approved by the SAB. The Case Review Group or the SAR Panel (if appointed) will also ensure the reviewer's report meets the approved terms of reference, is of a high standard and provides sound analysis. It will also ensure it includes SMART recommendations which can meaningfully be translated into an action plan for the multi-agency partnership. The report should be anonymised through redaction apart from the report author and the job titles and employing organisations of all the SAR Panel members.

All actions arising from reviews should be driven forward to ensure there is a lasting improvement to services, which safeguards adults from abuse and neglect. SAB member agencies confirm their commitment to providing regular updates to the Case Review Group on the actions taken by their organisation to implement any recommendations arising from reviews.

7. Links with other reviews

The SAB recognise that agencies and organisations have their own internal governance and statutory or contracting requirements in respect of investigating or reviewing serious incidents. This Framework is not intended to duplicate or replace these but seeks to enhance and complement current single agency arrangements by adding a multi-agency approach to support partner agencies to learn lessons from cases where there may have been poor outcomes and to use this learning to improve joint working in order to secure improved outcomes.

If there is a link with another review (for example a domestic homicide review (DHR), MAPPA review or LSCB serious case review (SCR)) consideration will be given to whether some aspects should be jointly commissioned, run parallel or dovetail. The SAB Independent Chair will liaise with the relevant decision maker/s to agree relevant matters and processes so to avoid duplication for families and staff.

The Case Review Group will seek and act on advice to ensure a review can proceed in a timely manner without prejudicing any ongoing criminal or civil legal proceedings.

8. Who will be involved in the review

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The SAB should also ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. In some cases, it may be

helpful to communicate with the person who caused the abuse or neglect. The safeguarding principles set out on pages 5 and 6 above should be adhered to.

9. Appointing an independent reviewer

The review should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. This individual must have appropriate skills and experience which should include[4]:

- 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;
- Inclined to promote an open, reflective learning culture.

10. Timescale for SAR completion

The Barnet SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required, e.g. where it isn't possible to mitigate against a likelihood of contamination of evidence or would prejudice ongoing court proceedings.

Every effort should be made while the SAR is in progress to:

(i) capture points from the case about improvements required; and
(ii) take corrective action.

11. SAR reports

Reports should

- provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- be in plain English; and
- contain findings of practical value to organisations and professionals.

12. Findings from SARs - SAB annual report

Findings from SARs must be included in the Barnet SAB annual report as well as actions taken, or intends to take in relation to those findings. Where the SAB

[4] paragraph 14.143 Care & Support statutory guidance 2014

decides not to implement an action then it **must** state the reason for that decision in its annual report.

13. Disseminating, embedding and evaluating impact of learning

The key components to improve multi-agency safeguarding practice are to learn from experience through audits and reviews of the partnership's safeguarding practice, drive forward improvement actions and then to ensure that the SAB embeds learning and evaluates the impact of that learning. This is duplicated from the Learning and Improvement Framework for ease of reference:

HOW	WHAT	WHO	ACCOUNTABILITY
Improvement Actions	Single and multi-agency action plans from case audits. Single and multi-agency action plans from case reviews	Agencies specified in audits and reviews or other reports	The SAB to hold partners to account. Independent Chair and sub-group chairs to ensure all sub-groups are driving forward actions. All partner agencies will report quarterly to Case Review Group.
Dissemination of learning	Multi-agency safeguarding training programme including E-learning. Multi-agency 'learning lessons from local reviews' half day workshops. Multi-agency briefings / newsletters. Publication of SAR final reports on website for a minimum of 12 months and thereafter to be made available upon request to facilitate national	Joint L&D (Learning & Development) sub-group oversees this via the Safeguarding Training Strategy. Case Review Group after consultation with the Independent Chair. SAB Partners	L&D reports quarterly to SAB. Case Review Group reports quarterly to SAB. All partner agencies report quarterly to L&D subgroup.

	sharing of lessons to be learned and good practice in writing and publishing SARs. Single agency training, briefings and other communication strategies.		
Embedding learning	Single and Multi-agency case audits. Case reviews. Reporting on action plans.	All sub group	sub groups report quarterly to SAB.
Evaluating impact of learning	Auditing and re-auditing of files & practitioner questionnaires/surveys to evaluate impact of lessons learned and how this has developed their day-to-day practice.	L&D sub-group	L&D reports quarterly to SAB on impact of learning.

Appendix 1
Safeguarding Adults Review Form (SAR1)

REFERRER	
Name	
Title	
Agency	
Address	
Telephone Number	
Email (gcsx)	
SENIOR MANAGER AUTHORISATION	
Name	
Title	
Agency	
Address	
Telephone Number	
Email (gcsx)	
Date referral authorised	

DETAILS OF ADULT CONCERNED	
Name	
Date of birth	
Date of death (if applicable)	
Address	
Health (physical)	
Health (mental)	
Agencies involved and principal contact.	

STATUTORY CRITERIA	
Is there reasonable cause for concern about how the safeguarding adults board, members of it or other persons with relevant functions worked together to safeguard the adult.	▪ Set out details of concerns around working together ▪ Which members or persons of the SAB
Is either condition 1 or 2 met:	Yes / No
Condition 1: **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).** **Condition 2:** **The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.**	Set out details of case
Potential for learning	
Any other relevant information	

Appendix 2:
SAR Scoping Form
SAR2

RESPONDING AGENCY:	
Name of person completing form	
Title	
Address	
Telephone Number	
Email & gcsx address	
Other relevant contact details	
Involvement with relevant adult and in what capacity	
Period of involvement	
Had your agency identified any safeguarding concerns and what steps were taken?	
Has your agency commenced its own review/audit of the case or is this intended?	
What potential for learning has been identified?	
Any other relevant information	

Appendix 3:
Referral recommendation / decision SAR3

REASON FOR REFERRAL:	
Name of relevant adult subject to request for SAR	
Date of birth of adult	
Date of incident or death of adult	
Date referral received	
Details of referrer	
Reason for referral	
Is there reasonable cause for concern about how the safeguarding adults board, members of it or other persons with relevant functions worked together to safeguard the adult.	▪ Set out details of concerns around working together ▪ Which members or persons of the SAB
Is either condition 1 or 2 met:	Yes / No
<u>Condition 1:</u> **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).** **<u>Condition 2</u>:** **The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.**	Set out details of case
Are the statutory criteria for a review met	Yes / No
Potential for learning	▪ Recommendations for type of review

	▪ Timescale
Which agencies are involved	▪ Which personnel / agencies should be involved in a review ▪ ensure there is transparency, independence, proportionality etc.
Next steps	▪ Referral to the Case Review Group ▪ Should a SAR Panel be convened to scope terms of reference etc.
Date considered by SAB	

Appendix 4: TYPE OF REVIEW

TYPE OF REVIEW OR AUDIT	DESCRIPTION	LEAD	ACCOUNTABILITY
Systems Approach Model	This model implies a broader concept than policies, procedures and protocols. It includes all the possible variables that make up the workplace and influence frontline workers in their engagement with families. As well as tangible factors such as procedures, tools, aids, working conditions, resources and skills, a systems approach also includes issues such as team and organisational cultures. This approach is based on the presumption that "human error is the starting point." This model has been developed by SCIE[5] for use in the multi-agency child protection field, resulting in the 'Learning Together model (Fish, Munro et al 2009). The SCIE Learning Together[6] is recognised as one which values practitioner contributions is sympathetic to the context of the case and is experienced as a more transparent by those involved. The 'Learning Together' model has been used for safeguarding adult reviews. Barnet Children's Service invested in this model in 2013	Case Review Group	Case Review Group reports to SAB. Learning is captured in the annual report.

[5] Social Care Institute for Excellence
[6] Piloted and evaluated during the 'Working Together to safeguard children' consultation period (Undertaking SCRs using the Social Care Institute for Excellence (SCIE) Learning together systems model: lessons from pilots March 2013.

	by training practitioners. Alternatively, independent accredited reviewers could be instructed.		
TYPE OF REVIEW OR AUDIT	**DESCRIPTION**	**LEAD**	**ACCOUNTABILITY**
Significant Incident Learning Process (SILP)	SILP has its origins in children's safeguarding; however, the model is now being used in adult safeguarding, for domestic homicide cases and for single agency reviews or mini-SILPs. This model explores the professional's view of the case at the time the events took place. It analyses significant events and deals not only with what happened but why it happened. SILP can show what affected the practitioner's actions and decision making at the time and what needs to change. It is based on systems methodology, with each review being scoped to offer a proportionate approach according to the requirements of the case. The systems focus reduces any notion of blame and trained reviewers should ensure practitioner events invite participation without fear of being blamed for actions taken in good faith[7]. More information is available at: http://www.reviewconsulting.co.uk/case-reviews/	Case Review Group	Case Review Group reports to SAB. Learning is captured in the annual report.

[7] SCIE: SARs under the Care Act: implementation support

Root Cause Analysis (RCA)	RCA has been used by health agencies as the method to learn from significant incidents. RCA seeks to find the systemic causes of operational problems to ensure that lessons are learned to prevent the same incident occurring elsewhere. It provides a systemic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. RCAs examine how and why patient safety incidents happen and analysis is used to identify areas for change and develop recommendations, which deliver safer care for patients. Suitably trained providers would need to be identified.	Case Review Group	Case Review Group reports to SAB. Learning is captured in the annual report.
TYPE OF REVIEW OR AUDIT	**DESCRIPTION**	**LEAD**	**ACCOUNTABILITY**
Appreciative Inquiry (AI)	AI is rooted in action research and organisational development, is a strengths-based, collaborative approach for creating learning change. SARs conducted as an AI seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded an adult 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	Case Review Group	Case Review Group reports to SAB. Learning is captured in the annual report.

	design practice improvements.		
Single agency case review / Individual Management Review (IMR)	Single agency audits / IMRs can be used on their own or as part of a detailed multi-agency review. It is a mechanism for enabling organisations to reflect and critically analyse their involvement with key individuals in the case, identify good practice and consider how systems, processes and practice could be improved. Analysis and reflection should result in SMART recommendations to improve practice.	Partner agency to lead	Report to SAB and captured in annual report
Multi-agency case review	This model would require all relevant agencies involved to complete an IMR of a safeguarding incident in the first instance. The multi-agency group would review the individual IMRs and develop a combined chronology to provide an overview of the case, identify gaps in service or practice, for example in communication between agencies, information sharing, risk assessment. The outcome should be a clear set of SMART recommendations to improve multi-agency practice. A facilitated workshop may be useful for this method.	Case Review Group to capture learning to improve safeguarding practice.	Report to SAB and captured in annual report.

TYPE OF REVIEW OR AUDIT	DESCRIPTION	LEAD	ACCOUNTABILITY
Multi-agency themed audits / deep dive reviews	Audit of safeguarding practice identified as an emerging issue for agencies from local data or from other sources. All audits should result in SMART recommendations to improve multi-agency practice. These may be useful to evaluate the impact of lessons learned from audits & reviews.	Performance and Quality Assurance sub-group (PQA).	Report to SAB and captured in annual report
Single agency themed audits	Audit of safeguarding practice arising from data from a single agency or from other sources with a view to making SMART recommendations to improve multi-agency practice. These can also be used to evaluate impact of lessons learned from audits and reviews.	Performance and Quality Assurance sub-group (PQA) to commission 2 single agency themed audits annually.	Report to SAB and captured in annual report
National research, published SARs, themed reports	Key messages from publications to be captured and cascaded, identifying learning and development.	Case Review Group and L&D sub groups to lead.	Report to SAB