August 2017

Sunderland Safeguarding Adults Board

SAFEGUARDING ADULTS REVIEW PROTOCOL

Date agreed by SSAB	**July 2015**
Date reviewed by LIIP	**August 2017**
Date of next Review	**August 2019**

1. INTRODUCTION

1.1 The purpose of this protocol is:

- To support the view that the public interest is best served by the presence of an effective and robust Adult Review process in relation to safeguarding adults.
- To provide guidance to Sunderland's Safeguarding Adults' Board in establishing Adult Reviews.
- To facilitate a consistent approach to the process and practice in undertaking an Adult Review.

1.2 The document *Safeguarding Adults* published by the Association of Directors of Social Services (ADSS) (October 2005) provides a National Framework of Standards of Good Practice and Outcomes in adult protection work, and recommends that:

"There is a 'Safeguarding Adults' Serious Case Review [1]Protocol. This is agreed on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a Serious Case Review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a Domestic Homicide Review should be clear".

And:

"There is a clear process for commissioning and carrying out of a Serious Case Review by the Partnership".

- Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work (ADSS, 2005)

1.3

The Care Act (2014) includes a requirement for Local Authorities to hold Safeguarding Adult Reviews in certain circumstances and for partners on the Safeguarding Adults' Board to co-operate in the process.

1.4 The Care Act (2014) also highlights six key principles that underpin all adult safeguarding work and which should be used to inform professional practice and assist Safeguarding Adults Boards to improve their local arrangements:

- **Empowerment –** People being supported and encouraged to make their own decisions and informed consent.

[1] Following the implementation of the Care Act (2014) the term 'Safeguarding Adult Review' replaces the term 'Serious Case Review'.

- **Prevention –** It is better to take action before harm 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 –** Accountability and transparency in delivering safeguarding.

1.5 When an adult at risk dies, and abuse or neglect are known or suspected in the death, local agencies need to consider immediately whether there are any other adults or children at risk of abuse or neglect who may need safeguarding. Thereafter, agencies need to consider whether there are any lessons to be learned from the circumstances of the case about the ways in which they work together to safeguard adults.

2. CRITERIA FOR A SAFEGUARDING ADULT REVIEW (SAR)

2.1 In accordance with the Care Act (2014) a Safeguarding Adults Board (SAB) must arrange a SAR when an adult in its area dies as a result of abuse or neglect[2], whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs 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.

2.2 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. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

2.3 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).

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 -

[2] Also included within the definitions of abuse and neglect are self-neglect and self-abuse

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

2.4 Using the Learning and Improvement in Practice Framework and associated Toolkit, the SAR Panel should consider what type of 'review' process 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. 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.

2.5 The following principles should be applied by SABs and their partner organisations to all reviews:

- 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;
- in support of the values of Making Safeguarding Personal (Making Safeguarding Personal: Guide 2014. ADASS, 2014) families 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.
- If an adult has no appropriate person to support them and has substantial difficulty in being involved in the review process, they must be informed of their right to an independent advocate.

3. INTERFACE WITH OTHER (STATUTORY) REVIEWS

3.1 Some external reviews led by other agencies may involve an adult at risk, or may concern an adult safeguarding case that is the subject of a SAR, such as a Children's Serious Case Review or a Domestic Homicide Review.

3.2 Where such reviews may be relevant to a SAR (e.g. because they concern the same perpetrator), consideration should be given as to the most appropriate and effective review methodology to achieve joint outcomes, enabling organisations and professionals to learn from the case, and avoid duplications of process, this may include:

- a jointly commissioned review, or
- parallel reviews, or
- a single review commissioned by only one agency – with a decision made as to who will be the lead agency for this

3.3 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a Children's Serious Case Review (SCR) and a Domestic Homicide Review (DHR).

3.4 When running a SAR and DHR or child SCR all relevant areas that need to be addressed should be established at the outset to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the Independent Chair of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

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

4. PURPOSE OF A SAFEGUARDING ADULT REVIEW (SAR)

4.1 The purpose of having a Safeguarding Adult Review is not to reinvestigate or to apportion blame; any evidence of professional negligence would be dealt with through appropriate routes such as disciplinary procedures in the relevant agency.

A Safeguarding Adult Review is not an enquiry into how an Adult at Risk has died or who is culpable; that is a matter for coroners and criminal courts respectively to determine as appropriate. Rather it is:

4.2 To identify any lessons that can be learned from the case:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of policy and procedures (both multi-agency and those of individual organisations);
- To inform and improve local multi-agency practice;
- To improve practice by acting on learning (developing best practice);
- To prepare and commission an Overview Report (depending upon the methodology chosen to support the review process) which brings together and analyses the findings of the various Single-Agency Reports from agencies in order to make recommendations for future action.

4.3 The focus of an Adult Review should be upon the way in which local professionals and agencies work together to safeguard and promote the welfare of vulnerable adults. The focus will be on the outcome of the process; the recommendations/actions and the monitoring and reviewing of the recommendations/actions. It will ensure that all appropriate actions have been taken with a view to learning lessons for the future both locally and nationally. It will also focus on how the learning is shared with appropriate partner agencies.

4.4 It is acknowledged that individual agencies may have their own internal/statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice. In order to conform to the objectives set for the Safeguarding Adults Board, there is an expectation that member agencies will support the Adult Review process as set out in this Protocol and/or other review processes which are initiated within the Learning and Improvement in Practice Framework. Also that, agencies will have in-house systems in place, which will identify cases which will meet the criteria for Adult Review.

4.5 SARs are not part of any disciplinary process but information that emerges in the course of a Review may indicate that disciplinary action should be taken under established procedures in the agency concerned. Alternatively, disciplinary action may be conducted concurrently and in some situations disciplinary action may need to be taken urgently to safeguard others. This will be a matter for the individual agency concerned.

4.6 Safeguarding Adults practice or procedural changes may be identified as being necessary at any point in the Review process and may be made immediately if identified as urgent in order to safeguard others.

5. REQUESTING A SAFEGUARDING ADULT REVIEW

5.1 The Safeguarding Adults Board will be the only body able to commission a SAR.

5.2 Any agency may refer a case believed to fit the criteria, outlined in Section 2 above, via a formal written request from the agency's safeguarding lead to the Chair of the Safeguarding Adults' Board.

5.3 Once an agency has identified that a SAR may be required, the request must be made immediately.

5.4 Information shared by the Coroner may be considered for a SAR or, where the criteria are not met, other form of review in accordance with the Learning and Improvement in Practice Framework.

5.5 In the event of an application being turned down, or an alternative form of review being undertaken, in accordance with the Learning and Improvement in Practice Framework, the Chair of the Safeguarding Adults Board will record the reasons in writing and share with the agency from whom the request originated.

5.6 Requests should include a brief written outline of the case and the factors and criteria that suggest a Safeguarding Adult Review is needed.

6. LEARNING AND IMPROVEMENT IN PRACTICE SUB-COMMITTEE

6.1 The Chair of the Safeguarding Adults' Board will inform the chair of the Learning and Improvement in Practice (LIIP) sub-committee of all requests.

6.2 The role of the LIIP sub-committee is to consider, in light of the information known by agencies, whether the criteria to conduct a SAR are met, as outlined in Section 2 above.

6.3 Where the criteria to conduct a SAR are not met the LIIP sub-committee will consider whether an alternative means of review should be initiated in accordance with the Learning and Improvement in Practice Framework.

6.4 Once all information is considered, and a decision is agreed, the LIIP sub-committee will inform the Chair of the Safeguarding Adults Board of their decision making and rationale.

6.5 The LIIP sub-committee's decision will be forwarded to the Chair of the Safeguarding Adults' Board within one month of a case being referred to them.

6. 6 The Chair of the Safeguarding Adults' Board should immediately inform:

(a) The Care Quality Commission (CQC) of any case that becomes the subject of a Safeguarding Adult Review

(b) The Safeguarding Adults' Board of the decision, brief circumstances and scope of the Review.

7. INITIATING A SAFEGUARDING ADULT REVIEW

7.1 If the request is agreed, a multi-agency Safeguarding Adult Review Panel will be set up within one month, with membership comprised of appropriate representatives of the agencies involved.

7.2 The Safeguarding Adults' Board will be responsible for the appointment of the Independent Chair for the panel and will ensure that they receive adequate support.

7.3 The Independent Chair will be responsible for establishing individual terms of reference and setting timescales for the SAR in agreement with the Safeguarding Adults Board. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted in accordance with the terms of reference.

7.4 Where appropriate, the Independent Chair will liaise with the Coroner's Office and/or Police to ensure that arrangements for undertaking a SAR are acceptable and do not conflict with any other investigative processes being undertaken.

7.5 The Chair of the Safeguarding Adults' Board will write to the Chief Officers of all the agencies involved for nominations to the SAR panel, and will request that records relating to the subject(s) of the SAR are made secure to prevent any adaptation.

7.6 It is acknowledged that resources are required for undertaking and supporting a SAR. It is the responsibility of the Safeguarding Adults' Board to ensure adequate resources and funding are in place in order for the SAR process to work effectively, to ensure an Independent Chair can be commissioned for each SAR and that the Chair and panel members receive adequate administrative support and will take a decision on how and from whom this will be provided.

8. CONDUCTING A SAFEGUARDING ADULT REVIEW

8.1 Initial panel meeting

This will agree:

- Terms of reference
- Methodology to be used for the review
- 'Evidence' required from each agency/participant
- The role the adult at risk and/or family will have in the SAR
- The need for Advocacy Services
- Support and other resources needed (any perceived deficits to be referred to the Chair of the Safeguarding Adults' Board)
- Timescales within which the SAR process should be completed – the SAR should be completed 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
- Dates, times and venues of meetings
- Media strategy
- Identification and dissemination of learning
- The nature and extent of legal advice required, in particular Data Protection, Freedom of Information and the Human Rights Act.
- Procurement of a Safeguarding Adult Review Independent Author

8.2 Consideration and due regard to family members, carers and the individual (where relevant) must be observed as all times in the SAR process, with consideration given to the involvement of an Independent Mental Capacity Advocate.

8.3 The panel should establish a suitable professional who can act as a single point of contact to the family members, carers and individual (where relevant) with regard to their involvement in the SAR process.

8.4 Media interest will be co-ordinated through the Chair of the Safeguarding Adults' Board and press statements will be co-ordinated through the Local Authority's Press Department, which would have the agreement of the Chief Executive.

8.5 Freedom of Information requests, in respect of request for information from SARs will be dealt with by the Local Authority through the Chair of the Safeguarding Adults' Board to ensure consistent and relevant information sharing.

8.6 The panel should establish a suitable professional who can act as lead to identify key themes and learning which will be shared with professionals as part of the lessons learnt from the SAR process.

8.7 Depending upon the SAR methodology, agencies may be required to produce an Individual Management Report (IMR) outlining any and all information provided to the SAR from that agency. Personnel compiling the report should have the appropriate skills, knowledge and training to produce the report.

8.8 IMR reports should:

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

8.9 In circumstances where agencies are not required to provide IMRs, for example when using a systems methodology, agency leads are expected to support the Independent Author in understanding the broader agency perspective, procedures and systems within their organisation.

8.10 The SAR Independent Author will produce an independent Overview Report, which collates the information, analyses it and makes recommendations. Where IMRs are produced (dependent upon the review methodology used) these will be made available to the SAR Independent Author. The

Independent Chair will ensure that the Overview Report is written and delivered within agreed timescales to an agreed format.

8.11 The draft report will be presented to the Review Panel comment and approval before being presented to the full Board for sign-off. Upon receipt of the report the Board will:

- Clarify to whom the report, or any part of it, should be made available, including the Care Quality Commission and the means by which this will be done;
- Disseminate report of key findings to interested parties as agreed;
- Agree arrangements to feedback to staff, family members or media as appropriate

8.12 The report will contain an Executive Summary which, subject to legal confirmation, will be made public on the Sunderland Safeguarding Adults Board website.

8.13 The Safeguarding Adults Board and Independent Chair of the SAR should always come to a decision as to whether the report is anonymised/redacted in order to protect the interests of the adult at risk and/or their family.

8.14 If at any stage whilst undertaking the SAR process information is received which requires notification to a statutory body, e.g. Health and Care Professions Council (HCPC) or Disclosure and Barring Service's Barred List, regarding significant omission by individual(s) or organisations this should be done without delay by the employing organisation in accordance with the HR policy and processes.

8.15 Safeguarding adults practice or procedural changes may be identified as being necessary at any point in the Review process and may be made immediately as urgent in order to safeguard others.

9. ACTING ON THE RECOMMENDATIONS OF THE SAFEGUARDING ADULT REVIEW

9.1 All actions and recommendations resulting from the SAR process will be incorporated into an action plan.

9.2 The SAR panel will take the lead in ensuring the Action Plan is developed.

9.3 The Action Plan will indicate:

- Responsibilities for various actions
- Timescales for the completion of agreed actions
- The intended outcome of the various actions and recommendations
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems.

9.4 The Safeguarding Adults Board will be responsible for ensuring the monitoring and implementation of the Action Plan. It will ensure that all recommendations are actioned and will request updates from the relevant agencies. The Action Plan will remain on the agenda until such a time that all actions have been completed.

10. FINDINGS FROM SAFEGUARDING ADULT REVIEWS

10.1 The SAR Panel will be responsible for identifying 'Lessons Learnt' from Reviews to be shared across the multi-agency partnership, focussing on key messages for practitioners and front-line staff. This may take the form of multi- or single-agency briefing sessions, briefing notes and updates to multi-agency safeguarding training provided by SSAB, via formal communication links with the training provider.

10.2 The findings from any SAR will be included in SSAB's Annual Report and will include what actions it has taken, or intends to take in relation to those findings. Where SSAB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation SSAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.