Derbyshire Safeguarding Adults Board
Safeguarding Adult Reviews (SARs) Protocol

Contents

1. Introduction

1.1. Section 44 of the Care Act 2014 requires Local Safeguarding Adult Boards to arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk.

1.2. A SAR must also be conducted when an adult has **not** died, but the Board knows or suspects that the adult has experienced serious abuse/neglect. In the context of SARs, this would include situations where a person 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.

1.3. Local Safeguarding Adults Boards are also free to arrange a SAR in other situations where it believes there would be value in doing so, including cases where good practice can be explored and highlighted or it is believed that there is learning to improve outcomes for people who are supported via the safeguarding process. The Derbyshire SAB SAR Sub-Group has an informal agreement with the DSAB Performance and Improvement Sub-Group (PISG) that cases which do not meet the SAR criteria can be referred to the PISG when it is felt that further assurance could be sought in the form of a multi-agency audit of the case.

1.4. A SAR aims to bring together and analyse the findings from individual agencies involved, in order to make recommendations for future practice where this is necessary and highlight good practice.

1.5. All relevant DSAB organisations must co-operate and contribute to a SAR and support with implementing and disseminating the lessons learnt.

2. Principles – Safeguarding Adult Reviews should:

2.1. Retain a focus on the adult/family/carers involved.

2.2. Be led by a suitably qualified professional who is completely independent to the case.

2.3. Focus on learning and not blame, recognising the complexity of circumstances and systems that professionals work within.

2.4. Be proportionate according to the scale and level of complexity of the issues being examined, and transparent about the way decisions are made and data is collected and analysed.

2.5. Develop an understanding of the underlying reasons that led individuals and organisations to act and respond as they did.

2.6. Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened.

2.7. Include involvement of the subject of the review and relevant significant family members/carers/friends where possible and appropriate.

2.8. Be inclusive of all organisations involved with the person and their family/carers and ensure information is gathered from frontline practitioners involved in the case.

2.9. Include individual organisational information from reports, timelines and supporting analysis as relevant to the methodology used.

2.10. Make use of relevant research and case evidence to inform the findings of the review.

2.11. Highlight good practice, where relevant.

2.12. Identify what actions are required to develop practice with a view to positive improving the outcomes for people in Derbyshire.

2.13. Produce a final report including sound analysis, written in a way to be understood by professionals and public alike. The DSAB will consider publishing SAR reports and learning summaries on a case by case basis.

2.14. The SAR should reflect the six key safeguarding principles:

1. **Empowerment**
2. **Protection**
3. **Prevention**
4. **Proportionality**
5. **Partnership**
6. **Accountability**

3. SAR criteria

3.1. S.44 of the Care Act 2014 states that the Safeguarding Adults Board is the only body that can commission a SAR and it **must** arrange a SAR if:

- The case involves an adult in the Derbyshire area with care and support needs (whether or not the Local Authority was meeting those needs); **and**
- There is reasonable cause for concern about how the Safeguarding Adults Board, its members or other persons with relevant functions worked together to safeguard the adult.

AND

- The person died (including death by suicide) 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 person died).

OR

- The person is still alive, but the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect.

3.2. The DSAB will only consider cases in its area in accordance with its obligations under s.44 of the Care Act 2014.

3.3. Where an adult is placed outside Derbyshire in another authority, the responsibility to conduct a SAR sits with the authority in which the person lived before they died.

4. Referrals to the SAR Sub-Group

4.1. A SAR referral can be made by any DSAB partner organisation via their safeguarding Lead/Board member. The referral should be made using the DSAB SAR referral form which should be emailed to the DSAB office DerbyshireSAB@derbyshire.gov.uk.

4.2. On receipt of the SAR referral, the SAR Sub-Group Chair will screen the referral, arranging a meeting with the referrer if required for a follow up discussion.

4.3. The SAR Sub-Group chair may ask the referrer for additional information if the referral does not provide evidence as to why the SAR criteria has been met.

4.4. If the referral does not provide sufficient information to justify consideration by the SAR Sub-Group, the referrer will be informed and the case will not be considered by the SAR Sub-Group.

4.5. If the SAR criteria appears to have been met, the referral will be considered by the SAR Sub-Group at the next scheduled SAR Sub-Group meeting. The referrer will be asked to attend the meeting to present the referral.

4.6. If a family member or carer wishes to submit a SAR referral for consideration, they should submit their request in writing to the Independent Chair at; DerbyshireSAB@derbyshire.gov.uk rather than using the professionals referral form.

5. Decision whether to initiate a SAR

5.1. If a recommendation is made by the SAR Sub-Group to commission a SAR, the Independent Chair of the DSAB will be notified in writing within seven working days and asked to approve the recommendation. The Independent Chair may request additional information before approval, or has the authority to challenge the recommendation made if necessary.

5.2. The referrer and DSAB Board members will be informed in writing of the decision from the DSAB Chair.

6. Challenge

6.1. The DSAB Independent Chair is responsible for deciding whether the threshold for a Safeguarding Adults Review has been met. Legal advice can be sought, if required, from Derbyshire County Council Legal Department who act as an advisor to the Board. In circumstances where it is felt necessary, independent legal advice can also be sought.

7. Commissioning a SAR

7.1. A Safeguarding Adults Review is be commissioned by the SAR Sub-Group. This includes the agreement of the appropriate methodology to be used (dependant on the scale and complexity of the case) and commissioning an Independent Reviewer (someone who is suitably experienced to lead the review with no previous involvement in the case). The panel for a review will usually comprise of relevant SAR Sub-Group members with additional panel members from other organisations (case dependant).

7.2. SARs in Derbyshire are funded by the three statutory members of the DSAB (Derbyshire Police, DCC Adult Care and Derby and Derbyshire ICB) with expenditure split equally across the three agencies. Consideration may also be given to seeking contributions from other relevant organisations (case dependant).

7.3. The impact and timing of any parallel processes must be acknowledged, for example, a criminal investigation or a Coroner's inquest. Communication should take place with all relevant bodies throughout the process.

7.4. The person/family/carer need to be notified and invited to contribute to the SAR as appropriate (consideration should be given to the potential impact on parallel process before contact is made). The SAR leaflet Safeguarding adult reviews - a guide for families, friends & carers should be shared during the first contact.

7.5. Where there are likely to be cross-border issues, neighbouring SABs should be notified and involved throughout.

7.6. The first panel meeting will include an introduction to the SAR reviewer, a discussion in relation to the scope and Terms of Reference for the SAR and an overview of the review methodology chosen, expectations and likely deadlines.

8. SAR Quality Markers

8.1. The Social Care Institute for Excellence's (SCIE) SAR Quality Markers Introduction to Safeguarding Adult Review Quality Markers - SCIE are used by the DSAB to support the SAR process and they help to ensure an effective and consistent approach is taken. SAR Quality Markers are a tool to support with commissioning, conducting and quality-assuring SARs, covering the whole process.

9. Links with other reviews

9.1. There is a statutory duty for Community Safety Partnerships to undertake a review in all cases of domestic violence related homicide. Consideration should be given to how SARs and Domestic Abuse Related Death Reviews can be managed in parallel in the most effective manner possible; this may include considering whether some aspects of reviews can be commissioned jointly to reduce duplication of work for the organisations involved, and to keep any distress to the family at a minimum.

9.2. Prior to a SAR/learning review or other review commencing, the DSAB Manager will communicate with the coroner's office in circumstances where an adult has died and

inform them of the intention to undertake a review. The DSAB and the Derbyshire coroner have adopted the National Safeguarding Adults Board Manager Network guidance on the interface between safeguarding adult reviews and coronial processes. The guidance aims to help identify how, when, and why joint working might be requested and/or be required and helpful. The intention is to minimise delays in respective statutory processes, as well as keeping relevant parties informed.

9.3. There are a number of other reviews undertaken which may overlap with the SAR process for example a LeDeR review or fatal fire review. When an organisation is undertaking a review and feels that the SAR criteria may be met, the SAR Sub-Group should be notified by email to DerbyshireSAB@derbyshire.gov.uk so that a discussion can take place as to whether there may be some learning to access, whether a joint review is required, or whether the review should be halted/replaced by a SAR.

10.Models/methodologies

10.1 The SAR Sub-Group will consider each case on an individual basis and agree the most appropriate methodology to use. Some possible methodologies are listed below but the list is not exhaustive, and the SAR Sub-Group may wish to consider other models of review or a combination of a number of methodologies.

10.1.SILP (Serious Incident Learning Process)

An external company who can be commissioned to undertake a SAR or learning review. A SILP-trained reviewer would be provided by the company to undertake the review.

Key agencies and professionals are invited to an event to examine the case together. Agencies will be asked to submit a chronology prior to the event. One facilitator will Chair the event, and another will note the learning. The process involves operational staff and their managers who would own the summary of learning, leading to a quick dissemination of the learning at an operational level. A second event may be arranged to review how the agreed actions have been met and how the learning was disseminated within agencies. A summary of the learning/action plans would be shared with the DSAB in the form of a written report.

10.2.Adult Practice Review (**Welsh Model**)

The methodology would be proportionate to the incident but would normally include a multi-agency timeline of significant events over a specific time period, used to highlight areas of learning and a supporting analysis report. Usually, there would be

three panel meetings and, where appropriate, a facilitated 'learning event' for practitioners would also take place before a reviewer would write the final report. The Welsh Government have trained reviewers for this model, but training has also been provided for the DSAB members to form a pool of staff who have a good understanding of this model. The reviewer can, therefore, be externally sourced or pulled from DSAB organisations, but would always be a professional who had no prior involvement in the case.

10.3. SAR in Rapid Time (SCIE)

The Safeguarding Adult Reviews in Rapid Time (SARiRT) model provides a process and related tools that support reviews to draw out systems learning to promote practical improvement using a timely and proportionate approach. Taking a systems approach, the model enables SABs to understand the social and organisational drivers for current practice problems. The process supports reviews to be turned around more quickly aiming for three months to produce the final report, and to provide a shorter more focussed final report.

10.4. Action Learning Approach

This is an approach characterised by reflective/action learning, identifying both areas of good practice and areas for improvement, but without apportioning blame. An independent facilitator and report author are used. A chronology and analysis would be provided by relevant agencies and this information would be merged to be used as a tool at a multi-agency learning event, attended by practitioners and line managers to 'walk through' the case and highlight the learning and good practice. Following the event, an overview report would be written by the author with an action plan/recommendations.

10.5. Traditional SAR Model

Consists of an Independent Chair, a multi-agency panel and independent reviewer (report author). Involved agencies produce IMRs (Individual Management Reports) outlining any relevant involvement, chronology and key issues. A combined chronology of events would be created to assist the author in writing their final report. The report would contain analysis, lessons learnt and recommendations.

10.6. Root Cause Analysis

Root Cause Analysis is a process which can be used to uncover the underlying causes of an incident. It looks beyond the individual/s concerned and seeks to understand the underlying causes and environmental issues in which the incident occurred. It identifies the sequence of events working back to the incident itself and identifies a range of factors that contributed to the incident, allowing organisations to learn and put improvements in place.

10.7. Multi-Agency Audit

If potential learning is identified in one specific area, an audit could be commissioned to look at other cases to assess whether there are potential training or system issues to be addressed. The DSAB Performance and Improvement Sub-Group (PISG) undertakes several multi-agency audits each year and themes or individual cases can be referred to the group to add to their future audit programme. Consideration could also be given to commissioning an external auditor to look at a particular theme within an organisation. An audit can allow for a swift response with actions agreed on the day but would not allow for in depth reviewing of complex information. Findings would be shared by the PISG with the SAR Sub-Group and the Board.

10.8. Single Agency Review

Single agency reviews may be conducted where agencies from the DSAB undertake their own reviews. The DSAB (via the SAR Sub-Group) may task an agency to undertake a Single Agency Review where there is a safeguarding element but no concerns regarding involvement of other agencies, e.g., an emerging pattern of issues/concerns or even where serious harm or abuse had been prevented by good practice. Any agency undertaking a Single Agency Review with a safeguarding element will be expected to inform the DSAB in order for the Board to consider transferable learning across the partnership. It is important to note that this is not an appropriate method of review for cases where the SAR criteria is met as it does not allow for multi-agency involvement and does not embody a wider viewpoint from partner agencies.

10.9. Peer Review

This could either be peers from within the same partnership or outside the partnership but within a specified region. Reciprocal arrangements can be set up so that it is a cost-effective method of reviewing, but capacity issues may restrict

availability and responsiveness and there is potential for a perceived lack of objectivity in high profile cases.

11.Reports and Publication

11.1. Final review reports should be presented to DSAB members for final sign-off on completion and shared with the Coroner where appropriate.

11.2. In order to provide transparency and to support national sharing of lessons learned/good practice, consideration will be given on a case-by-case basis to publishing learning from SARs and other reviews in some form (a learning summary or a redacted report may be published in place of a full SAR report to protect the identity of the person/family). Publication will be carefully planned, considering any parallel processes (e.g., criminal and coronial) and the person/family /carer would be informed prior to publication.

11.3. On an annual basis, the SAR Sub-Group will review SAR information published on the DSAB website and decide whether it should remain on the website, taking into consideration public interest, the wellbeing of family and carers and the need for practitioners to have access to learning from these reviews.

11.4. A communications strategy will be developed via the Board and communications leads to support publication and the management of any media enquiries.

11.5. The final report will be shared with any family/significant contributors to be review following sign off by DSAB members.

11.6. The DSAB will include findings from SARs in its annual report, and outline actions taken in relation those findings.

12.Dissemination of Learning

12.1. Recommendations and learning from SARs and other reviews commissioned by the DSAB will be circulated widely across the DSAB partnership and to other SABs, where relevant. The SAR Sub-Group is responsible for monitoring recommendations made in reports and obtaining assurance that recommendations have been fully implemented and that evidence has been provided to demonstrate implementation. The SAR Sub-Group reports to the DSAB quarterly, enabling the dissemination of learning to be scrutinised.

13.National Escalation

13.1. The National Analysis of SARs April 2017 to March 2019 provided priorities for sector-led improvement, including priority No 27, which was: 'How SABs, regionally and nationally, should discuss the role of SARs in sharing learning with central government departments and national regulatory bodies and holding them to account when findings require a response that is beyond the scope of local SABs.' Subsequent discussions with safeguarding policy leads at the Department of Health and Social Care clarified that a nationally agreed escalation protocol would be helpful to confirm a process for escalating issues that arise from local Safeguarding Adults Reviews, which require a national response. A process for escalation was agreed at the Executive meeting of the National SAB Chairs Network on 19th July 2021. SARs National Escalation Protocol

-End of document-