Derbyshire Safeguarding Adults Board
Safeguarding Adult Review (SAR) Protocol

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 for cases in other situations where it believes there would be value in doing so, including cases where good practice can be explored and highlighted.

1.4. Local Safeguarding Adults Boards can also arrange or request for another type of **non-statutory review**, for example, a learning review or single agency review in any other situations involving an adult in its area with needs for care and support, where important learning points may be apparent. The DSAB SAR Sub-Group will consider all such cases individually. The 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.

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

1.6. Both a SAR and non-statutory review aim 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.

2. Principles – Safeguarding Adult Reviews and other non-statutory reviews should:

2.1. Retain a focus on the adult/family 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 professionals were working 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 who did what and the underlying reasons that led individuals and organisations to act 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 Adult and their family and ensure information is gathered from frontline practitioners involved in the case.

2.9. Include individual organisational information from reports/timelines and supporting analysis.

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 identified outcomes.

2.13. Provide a final report including sound analysis, written in a way to be understood by professionals and public alike. The DSAB should consider publishing SAR reports and final reports/learning summaries from non-statutory reviews.

2.14. Lead to sustained improvements in practice and have a positive impact on the outcomes for Adults in Derbyshire.

2.15. The SAR/learning review or other review should reflect the six key safeguarding principles:

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

3. SAR criteria

3.1. 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:

- A referral is made and 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 safeguarding 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. It is important to note that the DSAB will only consider cases in its area in accordance with its obligations under s.44 of the Care Act 2014. 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 referral can be made to the SAR Sub-Group by any DSAB partner organisation via their safeguarding Lead/Board member.

4.2. The referral should be made using a DSAB SAR referral form.

4.3. The referral will be sent to the DSAB Project Manager DerbyshireSAB@derbyshire.gov.uk.

4.4. On receipt of the referral, the SAR Sub-Group Chair will be notified and if the criteria appear to be met the case will be considered by the SAR Sub-Group. A request will be sent to relevant agencies for written reports to be submitted to enable robust decision making at the meeting.

4.5. The 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.

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

5. Decision whether to initiate a SAR

5.1. The SAR Sub-Group will consider the referred case either at the next planned Sub-Group meeting or at an extraordinary meeting.

5.2. If a decision is made by the SAR Sub-Group to recommend that a SAR, or other type of review is commissioned, the Independent Chair of the DSAB will be notified in writing within seven working days and asked to approve the decision. The Chair of the DSAB may request additional information before approval or can challenge the decision made if necessary.

5.3. The referrer would be informed in writing of the decision within seven working days of the receipt of a decision from the DSAB Chair.

5.4. DSAB members would be informed of the decision at the next DSAB meeting.

6. Challenge

6.1. The DSAB Independent Chair holds final responsibility for deciding whether or not 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 review

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

7.2. Where the Board has decided that the threshold for a SAR has not been met, it may be that a non-statutory review is commissioned. This type of non-statutory review can take a number of forms, including the methodologies described at paragraph 9.

The SAR Sub-Group will continue to consider the s44 threshold during any non-statutory review and make further recommendations to the Board if necessary.

7.3. For SARs, budgetary support would be sought prior to the start of the SAR from the three statutory members of the DSAB (Derbyshire Police, DCC Adult Care and Derbyshire CCGs) and consideration will be given to seeking contributions from other relevant organisations (case dependant).

7.4. The impact and timing of any parallel processes must be acknowledged, for example, a criminal investigation, Coroner's inquest, domestic homicide review (DHR) or single agency review. Communication should take place with all relevant bodies throughout the process.

7.5. The adult/family/other significant people to the Adult need to be notified and invited to contribute as appropriate (consideration should be given to the impact on criminal and coronial proceedings before contact is made)

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

7.7. The first panel meeting will include a briefing session to support panel members and enable their understanding of the review methodology chosen, and expectations and likely deadlines. Themes for the terms of reference would be written and shared with the Independent Chair of the DSAB

7.8. Media and communications strategies need to be considered throughout (case dependant).

8. Links with other reviews

8.1. 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, LSCB Rapid Reviews and Domestic Homicide Reviews (DHRs) 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.

8.2. Prior to a SAR/learning review or other review commencing, the Independent Chair of the DSAB will communicate with the Coroner in circumstances where an adult has died and inform them of the intention to undertake a Review.

8.3. There are a number of reviewing processes undertaken within individual agencies represented on the DSAB, for example a serious incident process undertaken by NHS Trusts, or a fatal fire review. When an organisation is undertaking a review of this type, 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, or whether another level of review is needed.

9. Models/methodologies

9.1. No single model will be adopted by the DSAB when undertaking a SAR. The SAR Sub-Group will consider each case on an individual basis and decide on 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.

9.2. For non-statutory reviews the same models and methodology can be considered and the most proportionate will be selected.

9.3. **SILP (Serious Incident Learning Process)**

9.3.1. 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. http://www.reviewconsulting.co.uk/about-silp/

9.3.2. 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.

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

9.4.1. 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.

9.5. **Action Learning Approach**

9.5.1. 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.

9.6. **Traditional SAR Model**

9.6.1. 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.

9.7. **Root Cause Analysis**

9.7.1. 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.

9.8. **Multi-Agency Audit**

9.8.1. 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.

9.9. **Single Agency Review**

9.9.1. 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.

9.10. **Peer Review**

9.10.1. This can 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.

10. Reports and Publication

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

10.2. In order to provide transparency and to support national sharing of lessons learned/good practice, consideration should be given 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 adult/family). Publication would be carefully planned, depending on any parallel processes (criminal and coronial) and the adult/family would be informed prior to publication.

10.3. A media strategy will be developed via a multi-agency forum to support publication and the management of any media enquiries.

10.4. DSAB will include findings from SARs and learning reviews in its annual report, and outline actions taken in relation those findings.

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

11. Dissemination of Learning from all reviews

11.1. 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.

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