Derby Safeguarding Adults Board Safeguarding Adult Review (SAR) Protocol

V.2
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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 or another type of review such as a learning review or single agency review 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. The SAR Subgroup has an informal agreement with the Derby Safeguarding Adults Board (DSAB) Quality Assurance (QA) Subgroup that cases which do not meet the SAR criteria can be referred to the QA subgroup when it is felt that further assurance could be sought in the form of a multi-agency audit of the case.

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

1.5. 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.

2. Principles – Safeguarding Adult Reviews and other non-statutory 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 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 Derby.

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:

- The case involves an adult in the Derby 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 Derby 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 Subgroup

4.1. A referral can be made to the SAR Subgroup 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 office DSAB@derby.gov.uk.

4.4. On receipt of the SAR referral, the DSAB Business Manager will then share this information with the Independent Chair of the DSAB and SAR Chair.

4.5. A meeting will be arranged with the Chair of the SAR Subgroup, Head of Service: Safeguarding Adults and Professional Standards and the DSAB Business Manager. Following that meeting, a summary of the discussion and the likelihood of the referral meeting, the SAR criteria and referral form will be circulated to SAR Subgroup members.

4.6. The Independent Chair of DSAB will write to all DSAB members notifying them of the SAR Referral, advising them to take appropriate action(s) and requesting for agency information. These will be reviewed in the next SAR Subgroup and a decision made, which consists of DSAB Board members from Derby City Council Adult Social Care, Derbyshire Constabulary and Derby and Derbyshire Integrated Care Board (ICB). The referrer will be asked to attend the subgroup to provide additional information to help the subgroup members decide on the criteria.

4.7. If a family member wishes to submit a referral for consideration, then they should submit their request in writing to the Independent Chair at; DSAB@derby.gov.uk rather than using the professional's referral form.

5. Decision whether to initiate a SAR

5.1. The SAR Subgroup will consider the referred case either at the next planned subgroup meeting or at an extraordinary meeting.

5.2. If a recommendation is made by the SAR Subgroup to recommend that a SAR, or other type of review is commissioned, the Independent Chair of the DSAB will be notified and asked to approve the recommendation. The Chair of the DSAB may request additional information before approval or can challenge the recommendation 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 the threshold for a Safeguarding Adults Review has been met. Legal advice can be sought, if required, from Derby 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 is to be commissioned by the SAR Subgroup. This includes the agreement of the appropriate model/methodology to be used (dependent 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 SAR Panel will be made up from senior and experienced members who must not have been involved in case management or decision making for the case being reviewed and will have appropriate seniority and experience with regard to the case under review.

7.2. Where the Board has decided that the threshold for a SAR has not been met, it may be that a review is still commissioned. This review can take a number of forms, including the use of methodologies described in section 9. The SAR Subgroup should continue to consider the s.44 threshold during a review and make further recommendations to the Board if necessary.

7.3. SARs 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 dependent).

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 dependent).

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, Safeguarding Children Partnership 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 DSAB Business Manager will communicate with the Coroner Office 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 Subgroup should be notified by email to DSAB@derby.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 Subgroup 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 Subgroup 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.

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.

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 QA subgroup 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 QA Subgroup, with the SAR Subgroup 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 Subgroup) 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 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 adult/family). Publication will be carefully planned, considering any parallel processes (e.g., criminal and coronial) and the adult/family /carer would be informed prior to publication. On an annual basis, the SAR Subgroup 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.

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. The 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 Subgroup 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.

12. National Escalation

12.1. 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 proposal for escalation was discussed at SAB Chairs national and regional meetings during 2021, and the process was agreed at the Executive meeting of the National SAB Chairs Network on 19th July 2021.

SARs National Escalation Protocol

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