

**Safeguarding Adults Review Policy and Procedure**

**June 2021**

**Document information**

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| North Yorkshire Safeguarding Adults Board (NYSAB) | Susan Proctor  Independent Chair of NYSAB |
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**PART 1**

**Safeguarding Adults Review Policy**

# 1. Introduction

1.1 The Care Act 2014 provides a statutory basis for learning and review processes. Safeguarding Adults Reviews (SARs) provide an opportunity to learn lessons when abuse or neglect is suspected to be a factor in the death or serious harm of an adult with care and support needs.

1.2 It is the responsibility of all partner agencies to make a referral for a SAR where there are reasonable grounds to consider the criteria for a SAR has been met. Partner agencies should not draw their own conclusions on whether the criteria is met, but should make a referral to Learning and Review Group (LAR) which is a sub group of the North Yorkshire Safeguarding Adult Board (NYSAB).

1.3 All partner agencies have a responsibility to ensure all their staff know about SARs, their purpose and function. All partner agency staff must know how to refer a case for consideration to the LAR.

1.4 The LAR receives all SAR referrals and consider whether the referral meets the criteria to conduct a SAR, or whether any other action should be conducted to ensure learning takes place.

* 1. The LAR must include senior representatives from the following agencies:
* NYCC Health and Adult services
* North Yorkshire Police Constabulary
* Local Commissioning Groups
* Local NHS trusts
* NHS England

1.6 LAR will be considered quorate with representation from the three statutory agencies (police, local authority and health commissioning) who are required to have suitably senior designated deputies.

1.7 Once a case has been discussed and a decision reached, the NYSAB Independent Chair will inform the referrer of the decision.

1.8 If there is a difference of opinion about whether or not a referral is to be commissioned as a SAR and a decision cannot be reached by consensus, the NYSAB Independent Chair will have the casting vote / decision.

1.9 The NYSAB, via its Independent Chair, is the only body in North Yorkshire that commissions SARs.

1.10 The findings and actions from a SAR will be published on the NYSAB website and disseminated to relevant agencies, as described in Section 9. All partner agencies are required to share their experiences and lessons learnt both within their organisations and with organisations they work with to enhance safeguarding interventions with adults at risk of abuse and neglect within North Yorkshire. If criminal proceedings remain in place, the report will not be published until any criminal process is concluded on the grounds it may influence a trial; however, any learning can be embedded prior to completion.

# 2. Purpose

2.1 The purpose of a SAR is to determine what the relevant agencies involved in the case might have done differently that could have prevented harm or death. It is not an enquiry into how a person died nor is it to apportion blame. It is to learn from such situations, and to ensure that any learning is applied to future cases to prevent similar harm occurring again. It therefore requires outcomes that:

* + establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies were involved in the care and support of an adult at risk of abuse and/or neglect
  + review the effectiveness of safeguarding procedures, both of individual organisations and multi-agency arrangements
  + inform and improve future practice by acting on the findings (developing best practice across all organisations)
  + highlight any good or bad practice identified within the review.

2.2 Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

# 3. Criteria for a SAR

3.1 Following a serious incident, active consideration should be made as to whether or not a referral for a SAR is required. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

3.2 It is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (e.g. Serious Incident Policy) this should take place without delay and in line with the organisation’s internal policy requirements. Internal governance processes and SARs are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes and vice versa. Key questions to consider as part of internal processes include:

* + Was the incident reported internally?
  + Has an internal investigation been carried out?
  + Has the investigation highlighted concerns about any other organisations?
  + Has information come to light indicating abuse or neglect as a contributory factor?
  + Based on findings, are criteria for making a referral met?

3.3 Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with needs of care and support. If the SAB requests relevant information from a body or person (for example, in the context of a SAR) then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB. The test is that the information requested by the SAB must be for the purpose of enabling or assisting the Board to perform its functions of which carrying out SARs form part.

3.4 Cases should be referred to the NYSAB for consideration if:

* an adult with care and support needs has died **OR** been seriously harmed **AND**
* abuse or neglect, whether known **OR** suspected, are believed to have been a factor
* **AND** there are concerns about how partner agencies may or may not have worked together.

The LAR will consider whether a SAR will be commissioned, by assessing against the criteria below.

3.5 A SAR must be commissioned when:

* An adult with care and support needs (whether or not those needs are met by the Local Authority) in the Safeguarding Adults Board’s (SAB) area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

**Or**

* An adult with care and support needs (whether or not those needs are met by the local authority) in the SAB’s area has not died, but the SAB knows or suspects the adult has experienced serious abuse or neglect and there is concern the partner agencies could have worked together more effectively to protect the individual.

**Or**

* The NYSAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so. 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, and can include exploring examples of good practice.

**Or**

* The NYSAB can also consider conducting a SAR into any incident(s) or case(s) involving adults(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review.

3.6 The LAR is responsible for keeping a record of all cases that have been referred and considered for a SAR. As part of this process if the LAR, on reviewing agencies report and/or plans identifies any further actions required, will share these back to the agency concerned.

3.7 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 had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

# 4. Making a SAR referral

4.1 Any agency representative or professional MUST refer a case believed to meet the threshold of the criteria contained above by completing the SAR Referral Form (Appendix 1) and submitting to the LAR, using the NYSAB email address nysab@northyorks.gov.uk

4.2 Any agency or professional body, local councillors, Members of Parliament (MPs) and the coroner, should refer a case where they have concerns.

4.3 A case may be referred by other interested parties including the family. The address for written referrals is included in The Referral Form (Appendix 1).

4.4 All referrals made by professionals and other parties to the LAR MUST be made using Appendix 1. LAR may choose to invite those making a referral in their professional role to present their referral to a meeting of LAR. This is to enhance the opportunity to understand fully the context of the case prior to a decision being made.

4.5 Upon receipt of a referral, the NYSAB Governance Team will (a) acknowledge receipt of the notification, (b) quality check the referral, (c) advise the LAR Chair of the referral and (d) contact the relevant Coroners office (if applicable) to advise that NYSAB will be considering whether the referral meets the threshold for a SAR.

4.6 When a case is referred, the SAR will ordinarily be considered at the next available LAR meeting. Every effort will be made to make decisions as soon as practically possible. Once initial chronologies are received, a decision should be made within 10 working days. A sub group meeting will be arranged if the next LAR meeting is scheduled beyond this timescale.

4.7 Prior to the LAR meeting, each represented agency should research the information held on its systems about any new cases and bring any relevant information to the meeting. Where appropriate, requests for relevant information will be made to an individual’s General Practitioner (GP) and other relevant organisations (ie housing provider) using Appendix 2

4.8 If the LAR consider the threshold is NOT met, but there will be benefit in conducting some form of review, they will consider what type of ‘review’ process will promote effective learning and improvement action to prevent deaths or serious harm occurring in the future. These reviews can provide useful insights into the way organisations are working together to prevent and reduce the abuse and neglect of adults in North Yorkshire.

4.9 The LAR has options available where the statutory criteria for a SAR are NOT met:

* No further action
* A review which might include a learning event, either a Non-Mandatory SAR or a short briefing material highlighting key lessons to be learnt or a case file audit (learning review), where this is reasonable and proportionate
* A management review (within one or more organisations, i.e. Multi Agency Review or a Single Agency Review
* A discretionary Safeguarding Adults Review (SAR).
* Rapid Review Process

4.10 The rationale for decision making will be recorded on Appendix 3 and feedback will be provided to the referrer by the NYSAB Independent Chair.

4.11 Case file audits / learning review and/or management reviews (4.9 above) undertaken by individual organisations, will be formally requested in writing by the LAR chair.

# 5. Making decisions on SAR requests

5.1 In deciding whether a SAR should be conducted, the LAR must first consider whether there is a statutory obligation to undertake a SAR: using the criteria outlined in paragraphs 3.4 above. A SAR must be commissioned if there is a statutory requirement to do so.

5.2 In cases other than those involving a statutory obligation, the LAR should carefully consider whether commissioning a non-mandatory SAR would be a valuable exercise: i.e. whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focused on those cases that will yield the greatest learning and practice development.

5.3 In considering whether there are sufficient lessons to be learned and value in commissioning a non-mandatory SAR, LAR will use the guidance shown in Appendix 4.

5.4 Multi-Agency Working. When considering a SAR referral the LAR will need to establish if there were failings from a multi-agency or single-agency perspective. It is important that consideration be given to the increasingly complex landscape of the commissioning and provision of services.

5.5 The LAR should also consider whether another review or learning process has already commenced that would identify and share lessons to be learned, or which NYSAB could potentially feed into to avoid duplication (e.g. Domestic Homicide Review, Learning Disabilities Mortality Review (LeDeR), Independent Office for Police Conduct (IOPC) investigation or A Serious Incident process). It will be important to provide clarity about any governance issues if other processes are involved. If a person has died, the NYSAB Governance Team will contact the Coroner to identify whether an inquest has or will be held.

# 6. Making a decision on SAR methodology

6.1 Once LAR have agreed to commission a SAR, they must decide on the most appropriate methodology to use. See Appendix 4 for further guidance. This must be appropriate and proportionate to the case under review. The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

* **SAR Panel** – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review, but should comprise a minimum of three members in addition to a chair with a level of independence from the case under review.
* **SARP chair** – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience (see below).
* **Terms of reference** – published and openly available.
* **Early discussions with the adult and their family, carers and friends** – to agree to what extent and how frequently they will be involved in the SAR, and to manage expectations. This includes access to independent advocacy. See Appendix 6.
* **Appropriate involvement of professionals and organisations who were working with the adult** – to contribute their perspectives without fear of being blamed for actions they took in good faith
* **SAR report and recommendations**

6.2 The methodology selected must offer the most effective learning and involvement of key staff/family weighed against the cost, resources and length of time required to conduct the review.

6.3 The following should be considered in selecting a SAR methodology:

* Is the case complex, involving multiple abuse types and/ or victims?
* Is significant public interest in the review anticipated?
* Is large-scale staff/ family involvement wanted/ appropriate?
* Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
* Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
* What is the quickest and effective way to achieve the learning?
* Is a more appreciative approach required to review good practice?
* Are trained lead reviewers available in-house or nationally for the method selected?
* Can value for money be demonstrated?

# 7. Undertaking a SAR

7.1 Should the referrer challenge the decision of LAR, the Independent Chair of the NYSAB will reconvene the LAR to discuss the decision. Any challenge to the decision should be made in writing to the Independent Chair of the NYSAB or NYSAB Governance Team within 28 days of the feedback being received.

7.2 When the NYSAB Independent Chair confirms a SAR will be commissioned, An Independent Author will be commissioned and a Terms of Reference will be drawn up by the LAR. See Appendix 7. The Terms of Reference should reflect the six safeguarding principles set out in the Care Act and NYSAB’s Multi-Agency Safeguarding Policy and Procedures and should specify the time period the SAR will cover.

7.3 The Terms of Reference should be anonymised or consent should be sought if records are to include identifiable information.

7.4 The NYSAB Independent Chair will write to the family or significant others in cases where the subject is no longer alive to inform them of the SAR and explain the process and purpose. Reasonable and appropriate support and adjustments should be made by NYSAB as required to enable the adult(s), their family and/ or representatives to participate in the SAR. The LAR should nominate and agree an individual within the SAB partnership to communicate with the family to ensure they are clear about the role of the SAR. See Appendix 6 for further guidance.

7.5 In cases where the subject of the review is alive the LAR will seek to gain their consent to share information and complete the SAR as well as explaining the process and hearing their views. See Appendix 6 for further details about consent. To ensure that the subject is fully supported in this an advocate should be available to assist. If the subject does not have access to a suitable person, the LAR will arrange for an advocacy service to be available via the Local Authority contract. Where there is involvement of the family, in discussion with them, the LAR will agree how they and their loved one will be represented in the report.

7.6 The appointment of an Independent Author (IA) will be made via a request for Expression of Interest through all appropriate networks.

7.7 The selection of an IA will include a declaration that the IA does not hold any conflicts of interest in accepting this appointment. Should a conflict of interest arising during the process of the review the IA must declare this at the early opportunity to the chair of the panel.

7.8 Once the IA has accepted the commission the timescales for completing the SAR will commence. In every case, every effort will be made to complete the review within six months of the commission of the SAR. Where this will be impossible to achieve, reasoning and agreement will be provided by the chair of the NYSAB and recorded in the minutes of the LAR meeting. Interested parties, such as the family, will be notified.

7.9 Once the decision has been made to instigate a SAR, the NYSAB Chair will write to the heads of agencies concerned. They will advise them that a SAR will be carried out and (depending on the methodology to be used), will ask them to nominate a senior member of staff to collate a chronology and to write any necessary reports (for example an Individual Management Review). See Appendix 5. Contact will be made with the Senior Investigating Officer from North Yorkshire Police if criminal proceedings are in process to ensure any review does not undermine police investigations. The SAR may include information already gathered through other investigations. For example, Safeguarding Enquiries or Serious Incident Reviews.

7.10 In consultation with the appointed IA, the NYSAB Board Manager will identify and convene an appropriate SAR Panel (SARP) to meet at the earliest opportunity. The SARP will comprise of relevant senior representatives from the key agencies involved in the case.

7.11 The SARP will work to the Terms of Reference. The Terms of Reference will be reviewed at the first SARP meeting and may be expanded to reflect any other issues that have been identified that are not already covered. This review also helps promote ownership of the process and report by partner agencies. The LAR will agree any proposed amendments and the outcome shared back to the panel.

7.12 Agencies involved in the incident are required under the Care Act 2014 to cooperate with the SAR, and MUST supply all information that may be relevant within the identified timescale.

7.13 Agencies are responsible for ensuring staff are offered appropriate emotional support during the SAR process. This support should be clearly identified and communicated to all staff involved. The death or serious injury of an adult at risk will have an impact on staff and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff involved to the team, organisation or workplace. On occasion concerns about an individual’s practice may be raised through the review process and these concerns would be fed back to their agency through the SAR Panel Chair. Any action, including disciplinary action because of this, would remain the responsibility of the individual employing agency.

# 8. Outcomes from SARs

**The SAR Report**

8.1 The required output of a SAR – e.g. whether a report is needed, and/ or independent authorship – is to be set out in the SAR terms of reference as agreed by the LAR.

8.2 It is anticipated that for SARs and some non-mandatory SARs, a report will be required.

8.3 The NYSAB must ensure that there is sufficient analysis, scrutiny and evaluation of evidence throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SARP should form the basis of any SAR report, to be produced by the IA. The SARP will regularly meet during the SAR process to monitor progress and discuss whether any amendments to the Terms of Reference are required.

8.4 The SARP should receive and agree the draft report before it is presented to NYSAB via the LAR so that individuals are satisfied that the panel’s analysis and conclusions have been fully and fairly represented.

8.5 The adult(s) and/or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process. Ordinarily, 2 weeks will be afforded to read the SAR and provide any response.

8.6 NYSAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the NYSAB webpages and sharing the report with the SAR national repository where appropriate. The extent to which individuals and services are anonymised will be agreed prior to publication.

8.7 The chair of NYSAB will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period in line with NYSAB’s information sharing agreement, the General Data Protection Regulation and other legal requirements.

# 9. Implementation of Action from SARs

9.1. Every review will be supported by recommendations for the board to consider and adopt.

These recommendations MUST be SMART (specific, measurable, achievable, result-oriented and time-bound).

9.2 An action plan will be held by the LAR who will meet a minimum of four (4) times a year to review and check progress work on each action. This will record recommendations identified from any SAR, Multi Agency Review (MAR) or Single Agency Review undertaken to facilitate the learning across agencies.

9.3. The LAR is responsible for identifying an owner for each action and monitoring the actions on the composite action plan. It is the responsibility of NYSAB members to ensure learning and service change from any safeguarding review is understood, embedded and evidenced with their organisation. NYSAB members will be held accountable for these actions at board meeting. Regular reports on the work of LAR include ‘live’ referrals and reviews and the composite action plan will be presented to the NYSAB by the LAR chair.

9.4 Any actions relating to areas of work within the remit of NYSAB subgroups will be passed to them. These actions are owned by the relevant subgroup chair who will be expected to submit regular updates to the LAR.

9.5. For recommendations arising from an individual agency Independent Management Review (IMR) or from a Single Agency Review, it will be the responsibility of that agency to oversee and implement any actions identified and report back to the LAR.

# 10. Communication of outcomes of SARs

10.1 The NYSAB must include the findings from any SAR in its annual report and include what actions it has taken, or intends to take, in relation to the findings. Where the NYSAB decides not to implement an action then it must state the reason for that decision in the annual report.

10.2 As North Yorkshire Heath and Adult Services are the lead agency for adult safeguarding, media and communication issues will be co-ordinated by the North Yorkshire County Council’s Communications Unit on behalf of the Board and in collaboration with the communications teams of the other agencies involved. North Yorkshire County Council’s Communications Unit will be briefed as soon as a decision has been made to undertake a SAR and will be kept up to date with the progress of the review by the SAR Panel Chair or nominated officer.

10.3 Publication of the SAR will be managed through publication on the NYSAB website. At the point of publication the Board Chair will release a statement outlining the reasons for the key findings and required actions. An anonymised report will be published unless there are exceptional circumstances not to do so. In such an event, an Executive Summary may be made available.

# 11. Dispute Resolution during SAR Process

11.1 It is recognised that disputes may arise at any stage during the SAR process, including whether a SAR should be commissioned, how it is commissioned and any aspect of the outcome of the review, including the content of the report. A dispute may arise because of a disagreement or complaint from anyone involved in the SAR process.

11.2 The NYSAB retains ultimate responsibility for the SAR process. Where a dispute arises, it shall be dealt with as follows:

(a) Those responsible for the relevant part of the SAR process shall attempt to resolve the dispute, for example, the LAR before a report is commissioned and SAR panel and/or the report author during the carrying out of a review.

(b) The objecting party will provide written representation setting out their concerns to the IA within 7 working days of being advised that the final draft report will not be amended.

(c) The representations of the panel member and the IA will be considered by the Independent Chair. Where the Independent Chair is unable to resolve the dispute, they may recommend to NYSAB that a reference to the dispute, and that is was not possible to resolve it, should be included as a footnote to the report.

**PART 2**

**Safeguarding Adults Review Procedure**

# 12. Introduction to the procedure

12.1 The Care Act 2014, Section 44 requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area:

* dies either 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 adult;

**Or**

* if an adult has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care Act also states that SABs ‘are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.’

The adult experiencing abuse or neglect will be referred to as the adult throughout this procedure. The adult and/or their representative should be kept informed as described within both sets of procedures.

# 13. Safeguarding Adults Review Decision Making Procedure

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Stage of Procedure** | **Role** | **Responsibility** | **Maximum Timeframe** |
| **1** | **Notification** | 1. Notifications for consideration of a Safeguarding Adults Review should be made to the NYSAB Business Unit using form Appendix 1.   The Referral Form must be fully completed, include relevant and factual information, provide contact details for all agencies involved and be signed and dated by the referrer.  Referral Forms must be quality checked and screened by the NYSAB Governance Team.  Wherever possible, referrals should be forwarded by the agency’s NYSAB member. Where referrals are not forwarded by the agency’s NYSAB member, the NYSAB Governance Team will ensure that the NYSAB member has been informed of the notification.  Referrals from non-board member agencies should also be made to the NYSAB Governance Team. The referrer will be asked to complete the Referral Form if they have not already done so.  If a family member wishes to submit a referral for consideration, then they should submit their request in writing to the Independent Chair of NYSAB who will liaise to request a formal notification is raised.  Upon receipt of a notification, the NYSAB Governance Team will:   * 1. Confirm receipt of the Referral Form to the relevant NYSAB member and/or referrer   2. Screen the information received against the NYSAB SAR Policy and SAR Decision Support Guidance; and inform the NYSAB Independent Chair if the criteria appears to be met   3. Inform the referrer if the criteria is not met | Referrer  Referrer  NYSAB Governance Team  NYSAB Governance Team  NYSAB Governance Team  NYSAB Independent Chair  NYSAB Governance Team | In a timely manner and as soon as is reasonably practicable.  Same day as the notification is received. |
|  |  | 1. The **adult** and/or their representative will only be informed at this stage of the process if there *are exceptional circumstances.* | NYSAB Governance Team on behalf of the NYSAB Chair |  |
|  |  | 1. All appropriate agencies should be invited to attend the LAR meeting including the referrer (using the information outlined on the Referral Form). This may be in **addition** to those agencies that are established members of the Learning and Review Group (LAR). | NYSAB Governance Team |  |
|  |  | 1. All partner agencies will be sent a copy of the completed Referral Form and asked to complete an Initial Chronology Form (Appendix 2), outlining their involvement with the individual between specified dates. A clear deadline for returning the initial chronology will be given. | NYSAB Governance Team | As soon as practically possible |
|  |  | 1. At least three agencies should be represented at the meeting including the referring agency and the local authority in which the **adult** is/was normally resident. | LAR | Within 10 working days of all chronologies being returned. |
|  |  | 1. The NYSAB Independent Chair should be advised of the date of the meeting. It is not expected that the NYSAB Independent Chair will be in attendance at these meetings unless it is deemed to be necessary. | NYSAB Governance Team |  |
|  |  | 1. The Referral Form will not be considered by the LAR until all initial chronologies have been received. If there are significant delays the NYSAB Governance Team will escalate to the NYSAB Independent Chair. | NYSAB Governance Team |  |
| **2** | **Decision making** | 1. The information contained on the notification and initial chronologies should be considered by the LAR and a decision made using the NYSAB SAR Policy and NYSAB SAR Decision Support Guidance (Appendix 4) as to whether: 2. The criteria for a SAR are met or whether more information is required 3. The criteria are not met but another type of review would be appropriate 4. The criteria are not met and no further action is to be taken | LAR Chair/Sub-Group attendees | Within 10 days of all initial chronologies being returned completed |
|  |  | 1. The LAR should also take into account: 2. Whether any other Statutory Review Processes are taking place (Children’s SCR, MAPPA SCR etc.) 3. Whether any other significant processes are taking place (Police Investigation, Coroner’s Inquest, HSE Investigation) 4. What potential impact a SAR may have upon such investigations or proceedings, including whether a SAR should not start until after the proceedings are completed or, if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings 5. If there is a delay in the commencement of a SAR, then the LAR Chair will ensure that any learning at this stage of the process is identified and shared with relevant parties. 6. the delay of the commencement of a SAR should not delay the implementation of any learning to improve outcomes identified by single agencies | LAR Chair/ attendees | Within 10 days of all initial chronologies being returned completed |
|  |  | 1. If the criteria are not met, but another type of case review is felt to be appropriate, the LAR should recommend which type of review would maximise learning. Other types of review **may** include a Lessons Learned Review, Management Review or Single Agency Review; or a Reflective Practice Session. This list is **not** exhaustive. | LAR Chair/LAR attendees |  |
|  |  | 1. Where another type of review takes place the NYSAB will receive a report on the findings and any recommendations made. | Relevant NYSAB Member | Within 6 months of the review being initiated and at the closure of the other review process. |
|  |  | 1. The scope of the SAR should be clarified to include sufficient information to enable participating organisations to prepare for the first SARP meeting. The scope of the SAR will also determine the timeframe during which events in the ***adult’s*** life will be reviewed, taking into account the circumstances of the case. | LAR attendees |  |
|  |  | 1. The LAR should recommend to the NYSAB Independent Chair a suitable lead for the SARP. The Board Manager would normally be expected to undertake this role | LAR  Board Manager |  |
|  |  | 1. The LAR meeting should use its collective knowledge and experience to recommend to the NYSAB Independent Chair the most appropriate learning method for the case. There is a range of methodology options for conducting Safeguarding Adults Reviews. See Appendix 4. | LAR |  |
|  |  | 1. The NYSAB Independent Chair should be verbally advised of the recommendation, which will then be confirmed in writing using the SAR Decision Making document – Appendix 3. This will include the scope of the SAR and suggested methodology. | NYSAB Governance Team | Within 2 working days of the Referral Form being considered |
|  |  | 1. The final decision to conduct a SAR rests with the NYSAB Independent Chair. The Chair may wish to seek peer challenge from another SAB Chair when considering this decision. | NYSAB Independent Chair |  |
|  |  | 1. In the event of the NYSAB Chair disagreeing with the recommendation that the criteria for a SAR are met, further discussions should take place between the NYSAB Chair and the LAR Chair to establish a way forward. This could include commissioning a different type of case review (see 3 above). | NYSAB Independent Chair/LAR Chair | Within 5 working days of the Referral Form being considered |
|  |  | 1. The referring agency/person to be informed of the decision. Partner agencies to be informed via Appendix 5. Any challenge to the decision should be made in writing to the NYSAB Governance Team or Chair of the LAR | NYSAB Governance Team  Partner Agency | Within 5 working days of the recommendation being agreed.  Within 28 days of the feedback being received. |
|  |  | 1. Discussions should be held on **how** to inform the **adult** and/or their representative if there is to be a SAR. This should be completed as soon as practically possible. It will ordinarily be confirmed via telephone in the first instance, and followed by confirmation in writing. See Appendix 6. Otherwise the adult and/or their representative will not need to be informed if there is not going to be a SAR unless there are exceptional circumstances (see section 1.2) | The most appropriate person will be identified by the LAR |  |
|  |  | 1. The funding for the SAR/other type of review will be identified, agreed and appropriate commissioning arrangements put in place. | NYSAB Independent Chair |  |
| **3** | **SAR Panel (SARP)** | 1. All members of the SARP should be experienced and suitably qualified to contribute fully to the process. | NYSAB Independent Chair/NYSAB Members |  |
|  |  | 1. A point of contact should be identified for liaison with the **adult** and/or their representative. This point of contact will be a member of the SAB partnership. The degree of family/representative involvement will be discussed with the individual(s) and agreed at the outset. | To be identified by the LAR |  |
|  |  | 1. Consideration should also be given as to whether an outside expert should be consulted to help understand any specific aspects of the case. | NYSAB Independent Chair/LARG Chair |  |
| **4** | **Timescale for SAR Completion** | 1. The NYSAB will aim for completion of the SAR within 6 months of initiating it unless there are good reasons for a longer period being required. This could include for example, the need to delay the process due to legal proceedings or due to any relevant circumstances surrounding the adult. During any delay every effort should be made to capture learning from the case and apply to future practice. Following any criminal proceedings, the SAR should proceed without delay. | NYSAB Independent Chair | Within 6 months of initiation |

# 14. Safeguarding Adults Review Procedure Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Stage of Procedure** | **Role** | **Responsibility** | **Maximum Timeframe** |
| **1** | **Initial SAR Panel (SARP) Meeting** | 1. The first SARP meeting will review the: 2. Scope of the SAR 3. Methodology to be followed 4. Timescale for completion of the SAR 5. Arrangements for administrative support. | Independent Author/SARP attendees | Within 28 days of the SAR being initiated.  Reasonably extended with the permission of the NYSAB Independent Chair |
|  |  | 1. The scope and terms of reference should be proportionate to the nature of the case and should identify what appear to be the most important issues to address in identifying the learning from the case. | Independent Author/SARP |  |
|  |  | 1. The Terms of Reference will:  * Determine the timeframe during which events in the **adult’s** life will be reviewed, taking into account the circumstances of the case * Outline the methodology to be used * Reflect GDPR requirements and outline the arrangements for storage and transfer of personal information * Include a duty to report information to the Independent Chair if new information comes to light suggesting malpractice of individuals and/or organisations * Set out the arrangements for publication of the final report | Independent Author/SARP |  |
|  |  | 1. The process for undertaking SARs\* (methodology) ‘should be determined locally according to the individual circumstances. No one model will be applicable in all cases.’ Indeed a hybrid model could be the most appropriate. The ‘focus must be on what needs to happen to achieve understanding, remedial action and answers. \*’ \*Care and Support Statutory Guidance, DH | Independent Reviewer/SARP attendees |  |
|  |  | 1. Guidance on methodology from the Social Care Institute for Excellence can be found at <http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/> \*this guidance is **not** exhaustive and other methodologies can be used. |  |  |
|  |  | 1. In the event of any other Statutory Review processes (Children’s SCR, MAPPA, DHR etc.) or other significant processes (Police Investigation, Coroner’s Inquest, HSE Investigation) taking place the chairs of the respective review processes should formally discuss and consider how the interfaces between these should be managed in order to maximise learning for individuals and organisations, and to avoid duplication for families and professionals. | Independent Author |  |
|  |  | 1. The SARP should also: 2. Consider if there are any specific considerations around, equality and diversity 3. Consider how the review process should take account of previous lessons learned nationally, regionally and locally. 4. Consider if the SARP will need to obtain independent legal advice about any aspect of the review 5. Consider how matters concerning family and friends, the public and media should be managed. 6. Consider how to liaise with the adult and whether they require an advocate to support them 7. Ensure that any learning identified at an early stage of the process is shared and acted upon. | Independent Author/SARP attendees |  |
|  |  | 1. The process will be supported by the North Yorkshire Safeguarding Adults Board (NYSAB) Governance Team. | NYSAB Governance Team |  |
| **2** | **Process** | 1. Some or all of the following actions/stages will be appropriate dependent on which methodology is being followed and will be determined by the Independent Author and the SARP: 2. Identify the evidence required from each agency/organisation including a chronology of events 3. Produce/review of relevant evidence 4. Analysis of evidence 5. Produce Individual Management Reports (IMRs),outlining involvement and key issues including evidence of benchmarking against specific standards and guidelines. 6. Hold learning events to consider what happened and why, areas of good practice, areas for improvement and lessons learned 7. Hold event to consider first draft of the overview report and action plan 8. Formulate an Overview Report with analysis of key issues, lessons learned and recommendations 9. Produce an action plan in response to the lessons learned | Independent Author/SARP attendees |  |
|  |  | 1. Liaison should take place with the **adult**, their advocate, relative or carers throughout the process. The frequency of contact will be agreed at the outset. |  |  |
| **3** | **Timescale** | 1. The SARP will aim for completion of the SAR within 6 months of its initiation, unless there are good reasons for a longer period being required. This could include the need to delay the process for legal proceedings or due to relevant circumstances surrounding the adult. During any delay every effort should be made to capture learning from the case and apply to future practice. Following any criminal proceedings, the SAR should proceed without delay. | Independent Author/SARP |  |
|  |  | 1. The LAR Chair should report regularly on progress to the NYSAB. | LAR Chair | Bi-monthly |
| **4** | **Reports** | 1. All reports should be anonymised unless the family requests otherwise. Discussion will take place with the adult and/or their family regarding the use of pseudonyms within the report. The report should be ‘written in plain and easy to understand language, provide a sound analysis of what happened and why; and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a reoccurrence\*. ‘ \* Care and Support Statutory Guidance, DH   See Appendix 6 | Independent Author | Within 6 months of the SAR being initiated  Reasonably extended with the permission of the NYSAB Independent Chair |
|  |  | 1. The Independent Author should present the Final Report; Executive Summary and draft action plans to a SAR Governance Group meeting for agreement. The agreed documents should then be forwarded to the NYSAB Independent Chair by the Governance Team. | Independent Author |  |
|  |  | 1. The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the NYSAB | Independent Author  NYSAB Independent Chair/Board Members | Within 6 months of the SAR being initiated  Reasonably extended with the permission of the NYSAB Independent Chair |
|  |  | 1. A reason should be given for any decision where the NYSAB decides not to implement a recommended action. | NYSAB Independent Chair |  |
|  |  | 1. Liaison should take place with the adult and/or their representative regarding the final report and allow for feedback. | Lead Reviewer/NYSAB Governance Team |  |
|  |  | 1. The Local Authority will ensure there are appropriate arrangements in place to support the adult and/or family members in preparation for, and following the publication of the report. | Independent Author/NYSAB Governance Team |  |
| **5** | **Sharing the Learning** | 1. The NYSAB should agree the dissemination of learning, which will include providing feedback to staff and agencies involved in the case. | NYSAB Governance Team |  |
|  |  | 1. The NYSAB should arrange SAR briefings for a wider audience to share the lessons learned from the case. | NYSAB Governance Team |  |
| **6** | **Publication of Reports** | 1. All Safeguarding Adults Reviews conducted within the year will be referenced within the North Yorkshires Safeguarding Adults Board’s Annual Report together with any actions that it has taken or intends to take. All reports will be anonymised unless family have specified otherwise. The Annual Report will also include the reason for any decision where the NYSAB decides not to implement an action. | NYSAB Governance Team |  |
|  |  | 1. The NYSAB will publish Safeguarding Adults Reviews together with the associated Delivery Report on its website. | NYSAB Independent Chair/Board Members |  |
| **7** | **Monitoring** | 1. Arrangements for the monitoring of actions plans should be put in place as follows: 2. Individual agency action plans to be monitored by the agency concerned 3. Overall monitoring to be undertaken by the LAR 4. A report on the implementation of action plans across partnerships to be given to the NYSAB at an agreed frequency 5. Liaison to continue to take place with the **adult** and/or their representative as appropriate | NYSAB Members  LAR Chair  NYSAB Governance Team | Ongoing  Ongoing  At an agreed frequency  As appropriate |
|  |  | 1. Family/representatives will be informed of progress against the action plan 6 months after publication of the SAR. | NYSAB Governance Team | 6 months post publication of the report |

**Safeguarding Adults Review Referral Form**

North Yorkshire SAB considers every SAR referral based on whether it meets the criteria for a Safeguarding Adults Review.

The Board needs as much information as possible to enable members to make a proportionate decision as to how to respond to a SAR referral, ensuring, if the case is accepted for a review, that maximum learning can be achieved. Please therefore complete as much information on this form as possible.

**If you have any questions, please do not hesitate to contact the SAB Business Unit via** [**nysab@northyorks.gov.uk**](mailto:nysab@northyorks.gov.uk)

**A Safeguarding Adult Review will only be considered if Section 1 (below) is met and Section 2 or 3 are met. Please select all that apply.**

|  |  |  |
| --- | --- | --- |
| **1.** | **There is reasonable cause for concern about how the North Yorkshire Safeguarding Adults Board, its members or organisations worked together to safeguard this adult.** |  |
| **2.** | **The adult died and the North Yorkshire Safeguarding Adults Board knows/suspects this was as a result of abuse or neglect.** |  |
| **3.** | **The adult is still alive but the North Yorkshire Safeguarding Adults Board knows or suspects the adult has experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.** |  |

**Details of adult at risk:**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of birth** |  |
| **Date of death (if applicable)** |  |
| **Ethnicity** |  |
| **GP (if known)** |  |
| **Family/next of kin/advocate/representative** |  |
| **Health and/or other care and support needs** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Brief Details of the Incident | | | | | |
|  | | | | | |
| **Main** type of abuse/neglect identified: | | | | Choose an item. | |
| **Other** types of abuse/neglect identified (please tick as appropriate): | | | | | |
| Discriminatory | Domestic Violence | Financial | Modern Slavery | | Neglect |
|  |  |  |  | |  |
| Organisational | Physical | Self-Neglect | Psychological | | Sexual |
|  |  |  |  | |  |

**Other Agencies Involved;**

|  |  |
| --- | --- |
| **Name** |  |
| **Agency** |  |
| **Role** |  |
| **Address** |  |
| **Telephone number** |  |
| **E-mail** |  |

**Details of individual/organisation referring the case for consideration for a SAR**

|  |  |
| --- | --- |
| **Name** |  |
| **Position/designation** |  |
| **Organisation** |  |
| **Address** |  |
| **Contact telephone** |  |
| **Contact email** |  |

|  |  |
| --- | --- |
| **Safeguarding Lead** |  |
| **Position/designation** |  |
| **Contact telephone** |  |
| **Contact email** |  |

|  |  |
| --- | --- |
| **Date of request** |  |

|  |
| --- |
| **ANY OTHER REVIEWS PENDING OR COMPLETED**  (e.g. Serious Incidents, MAPPA, Domestic Homicide, Single Agency/Management Reviews, Children’s Serious Case Reviews, Police internal review processes, referred to Coroner). |
|  |

Please return the completed document to nysab@northyorks.gov.uk

If a family member wishes to submit a referral for consideration, then they should submit their request in writing to the Independent Chair at;

Independent Chair

North Yorkshire Safeguarding Adults Board

c/o Health and Adult Services

North Yorkshire County Council

County Hall

Northallerton

DL7 8AD

**Safeguarding Adult Review – Initial Chronology**

|  |  |
| --- | --- |
| **Organisation:** |  |
| **Name of Adult:** |  |
| **DOB:** |  |

A SAR referral has been submitted to the NYSAB and will be discussed at the upcoming Learning and Review Group meeting. We ask that all agencies consult their records on this individual between the dates of  and  in order to build a greater understanding of the circumstances surrounding this case. In addition to this, we ask each agency to provide a **brief** summary of any significant historical and useful information relating to this individual. Including: is there a review/ investigation process being undertaken by your organisation; have you identified any early learning for your organisation following completion of this chronology; and has any learning already been implemented within your organisation regarding this incident?

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Who was Involved?** | **What Happened?\*** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Summary and Historical Information**  Including: is there a review/ investigation process being undertaken by your organisation; has any practice been identified that falls either below or outside your organisation’s policies and standards; have you identified any early learning for your organisation following completion of this chronology; has any learning already been implemented within your organisation regarding this incident? |
|  |

Once complete please return to [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk)

**SAR REFERRAL RECOMMENDATION AND DECISION TEMPLATE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name of Adult** |  | **Date of Birth** |  |
| **Date of Serious Incident** |  | **Date of Death** (if applicable) |  |
| **Date of Meeting** |  | **Time of Meeting** |  |

|  |  |  |
| --- | --- | --- |
| **Present** |  |  |
| **Name** | **Job Title** | **Organisation** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Other Reviews or significant processes currently being undertaken**  (e.g. Serious Incident, Multi-Agency Public Protection Arrangements (MAPPA), Domestic Homicide Review, Single Agency / Management Reviews, Children’s Serious Case Review, Police Investigation, Coroner’s Inquest, Health & Safety Executive Investigation, Other) | | |
| **Type of Review** | **Lead Officer** | **Contact Number** |
|  |  |  |
| What potential impact may a SAR have upon any of the proceedings above? | | |
|  | | |

***Please note this document should be completed in conjunction with the ‘SAFEGUARDING ADULTS REVIEW (SAR) Decision Support Guidance’ (Appendix XX).***

**The NYSAB via the Learning and Review Group will consider undertaking a Safeguarding Adults Review when it is known or suspected that:**

|  |  |  |
| --- | --- | --- |
| **1.** An adult with care and support needs has died OR been seriously harmed, AND abuse or neglect, whether known OR suspected, are believed to have been a factor, AND there are concerns about how partner agencies may or may not have work together. | **Yes** | **No** |

**If YES, a recommendation for SAR to Independent Chair for decision-making.**

**OR**

**If No, see alternative recommendations in points 2 and 3 below;**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 2. Non-Mandatory SAR |  | Management Review |  | Single Agency Review | |  |
| Serious Incident |  | Reflective Practice |  | Other (please describe) | |  |
| Rationale for Decision | | | | | | |
|  | | | | | | |
| Agency responsible for feeding back outcome of review back to the LAR within 6 months | | | | |  | |

|  |  |
| --- | --- |
| 3. No Further Action |  |
| Rationale for Decision | |
|  | |

|  |  |
| --- | --- |
| **Scope** - The content included within this summary should provide sufficient information to enable participating organisations to prepare for the first SAR Panel meeting. | |
| Recommended Timeframe for Review |  |
| Recommended Lead for SAR Panel |  |
| Recommended Learning Methodology |  |
| Are there any reasons to delay the commencement of the SAR? If Yes, please explain | |
|  | |

|  |  |  |
| --- | --- | --- |
| **Any other actions recommended by SAR Sub-Group** | |  |
| **Action to be Undertaken** | **By Whom** | **Deadline** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signature of SAR Sub Group Chair** |  | **Date** | |  | |
| **Recommendation Agreed** |  | Yes |  | No |  |
| **Signature of NYSAB Chair** |  | **Date** | |  | |

**SAFEGUARDING ADULTS REVIEW (SAR)**

**Decision Support Guidance**

**Introduction**

There is a need to apply and demonstrate a consistent approach to decision making in relation to Safeguarding Adults Reviews notifications. This decision support guidance has been developed specifically to be used by the SAR Sub-Group when considering SAR notifications.

**The Care Act 2014**

The Care Act 2014, which came into force in April 2015, created a new legal framework for Adult Safeguarding. This included outlining the circumstances in which Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR). The Care Act further placed a duty on all Board members to contribute to the undertaking of such reviews.

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. The Care and Support Statutory Guidance issued under the Care Act by the Department of Health also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

**Using this guidance**

This guidance includes a flow chart which sets out the stages of decision making in the event of a fatal and a non-fatal incident. The SAR Sub-Group should use this flow chart to determine if the criteria for a SAR are met, if an alternative review should be recommended or if no further action is required. In addition the seriousness of abuse must be considered and a separate table appears on page 3 to illustrate the relevant types of abuse.

**Criteria for Safeguarding Adults Review**

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs):

1. dies either 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 adult;

Or

2. if an adult has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care Act also states that SABs ‘are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.’

**Serious Types of Abuse**

The following table indicates the types of abuse that are considered to be serious in nature and relevant to decision making in relation to SARs.

|  |  |  |  |
| --- | --- | --- | --- |
| **Types of Abuse** |  |  | |
| Discriminatory | •  • | Being refused access to essential services  Hate crime resulting in serious injury, death, fear for life | * Hate crime resulting in attempted murder/murder * Honour based violence |
| Domestic Abuse | •  •  • | Permanent harm or death due to a lack of response to alleged  domestic abuse Use of an implement Female Genital Mutilation (FGM). | * Honour based violence * Please also refer to other categories of abuse; physical, neglect and sexual |
| Financial | • | Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control. | |
|  | • | Adult denied access to his/her own funds or possessions. | |
|  | • | Fraud/exploitation relating to benefits, income, property or will. | |
| Modern Slavery | • | Incidents of modern slavery resulting in serious injury or death | |
| Neglect and Acts of Omissions | • | Ongoing lack of care to the extent that health and well-being deteriorate significantly, for example: pressure wounds, dehydration, malnutrition | |
|  | • | Failure to arrange access to life saving services or medical care | |
| Organisational | • | Staff using their position of power over adults in their care | |
|  | • | Over-medication and/or inappropriate restraint used to manage behaviour | |
|  | • | Widespread consistent ill-treatment | |
| Physical | •  •  •  • | Inexplicable marking on a number of occasions Accumulations of minor  incidents  Deliberate maladministration of medications  Inappropriate restraint | * With-holding of food, drinks or aids to independence * Inexplicable fractures/injuries * Grievous bodily harm/assault with or without weapons |
| Psychological/ Emotional | • • | Denial of basic human rights/ civil liberties in a care/ health setting Vicious/ personalised verbal attacks | |
| Self-Neglect | • | Permanent harm or death due a lack of response to reported and/or suspected self-neglect | |
| Sexual | • | Sex in a relationship characterised by authority inequality or exploitation | |
|  | • | Sex without consent (rape) | |
|  | • | Sexual acts against adults as listed in the Sexual Offences Act 2003 | |

**Multi-Agency Working**

When considering a SAR notification (SAR01) the SAR Sub-Group will need to establish if there were failings from a multi-agency or single-agency perspective. It is important that consideration is given to the increasingly complex landscape of the commissioning and provision of services.

Safeguarding Adult Review (SAR) - Decision Making Process



**Types of Review and Methodologies**

The Safeguarding Adults Board should weigh up what type of review process will promote effective learning and improvement to practice. The following principles should be applied when making this decision:

a. The approach taken to review a case should be proportionate according to the scale and level of complexity of the issues being examined

b. 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

c. 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

d. 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

e. The Board 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 example because of potential prejudice to related court proceedings.

Some examples of methodologies are provided below.

***Traditional Serious Case Review Model***

The traditional Serious Case Review (SCR) methodology pre-dates the Care Act 2014 and remains a well-used model. It involves appointing an Independent Report Writer/ Chair to collate and analyse information submitted by the agencies involved in the case.

The individual agencies involved in the case are required to collate their chronology and an Individual Management Review (IMR) report. The IMR report writer will be a senior manager within the organisation and not directly linked to the case or be line managing staff who may have worked on the case. The IMR report writer is required to collate their agency’s chronology, review their agency’s records and to meet with staff who were involved to gain insight into their involvement and also to hear what they have learnt from the case. The IMR report and the agency chronology will be provided to the Independent Overview Report Writer who will create the final report.

***Appreciative Inquiry***

The Appreciative Inquiry approach asks generative open questions about what worked well, alongside what might and should be different in the future. This is a reflective approach using collaborative techniques to identify areas of good practice, as well as for improvement. This is usually in the form of a facilitated learning event.

A facilitator(s) skilled in the Appreciative Inquiry approach will be appointed and may be from one of the Board’s partner agencies, however, the facilitator(s) must be independent of the agencies involved.

A planning meeting between the facilitator(s) and the SARP is held to agree the scope for review and who will need to be involved.

An Appreciative Inquiry Review meeting will be held, the length of the meeting is dependent on the case and could range from half a day to two or more days. The meeting has the following stages:

1. Introduce themselves and their best strengths in challenging times.

2. Inquire into one another’s work with the individual, asking about:

a. those interventions that were successful in keeping them safe

b. those things that with the benefit of hindsight should have been done differently.

3. Create a multi-agency timeline story by sharing practitioner’s answers to the two questions above

4. Reflect together on all the things that worked well, and all the areas that people could now see should have been done differently

5. Seek new ideas about the redesign of those things that must change to enable the whole system to get better at keeping adults safe

6. Make individual and shared commitments to on-going development, action and change.

The first report is then drafted by the Appreciative Inquiry facilitator/s and shared with participants for their comments/amendments. The report is then finalised.

***Significant Incident Learning Process (SILP)***

SILP 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.

The SILP approach is rooted in systems methodology, with each review being scoped to offer a proportionate approach according to the requirements of the case. Families and significant others are offered opportunities to engage with the reviews in a variety of ways. SILP reviews see equal value in learning from good practice.

***Peer Review***

This option accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, (for instance SAB members), or other local authority areas.

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Likewise, there can be flexibility regarding the exact methodology to be adopted in order (see options above) to achieve the desired outcomes of the review.

The appointed peer team/panel will agree the terms of reference for the review with the Safeguarding Adults Review Committee

Dear

Re: Name: DOB/DOD: Address:

I am writing to inform you that the North Yorkshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death.

Safeguarding Adult Reviews are undertaken when a vulnerable adult dies or is seriously harmed and abuse or neglect is suspected and there are lessons to be learned about the way agencies have worked together to prevent similar deaths or injuries in the future. A Safeguarding Adult Review looks at how local agencies and organisations have worked together to provide services and is completely separate to any investigation being undertaken by the police or Coroner.

If your agency has had involvement you are likely to be required to be involved in the Safeguarding Adult Review. Your agency may be required to complete an Individual Management Review and nominate a representative to sit on the Safeguarding Adult Review Panel or alternatively you may be asked to participate in a Case Group or Review Group. This will all be explained once we have the information.

I look forward to hearing from you shortly to enable the Safeguarding Adult Review Panel to be set up.

Yours Sincerely

Independent Chair North Yorkshire Safeguarding Adults Board



A Safeguarding Adult Review (SAR) looks at how local organisations worked together to support the adult at risk at the centre of the review. Safeguarding Adults Boards will carry out a SAR whenever an adult at risk has been seriously harmed or died in circumstances where abuse or neglect is suspected or confirmed and there are concerns that agencies did not work effectively.

In relation to consent, the Care and Support Statutory Guidance states that “informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement”. The Statutory Guidance further states that “Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (for example, because there is a risk that others are at risk of serious harm) and wherever possible the Caldicott Guardian should be involved”.

The following sets out a set of principles based on good practice regionally and nationally that Safeguarding Adult Boards should consider when involving families as part of the SAR process. They should be read in conjunction with the SCIE SAR Quality Markers Checklist (available at https://www.scie.org.uk/safeguarding/adults/reviews/library/apply). Each case will be unique, and it is therefore important that careful consideration is given to the best way of notifying and involving the adult, family and friends.

Consideration

• Safeguarding Adult Boards must have an agreed and documented process for identifying, considering and making decisions on undertaking a Safeguarding Adults Review.

• As part of this process clear consideration should be made at the outset on the potential involvement of families and the Board should be notified of this and clarify how they are to be involved.

• The involvement should be clearly documented in the Terms of Reference for the SAR.

• If a decision is taken to not involve the adult at risk and/or their families, the reasons should be informed by legal advice and clearly documented.

Notification - It will be a very sensitive time for everyone, and consideration should be given at an early stage of the following:

• How the notification will be made.

• The ongoing identified support to those involved (how and who will provide it)

• How they will want to be involved

• The purpose, process and parameters of the SAR been communicated in the most appropriate setting or method to ensure that these can be understood and convey respect to those involved

• Informing the adult or family/friends about how the process works and what role they will have in shaping this.

• Early notification needs to take place with the adult at risk, family/friends to agree how they wish to be involved and how they should be supported. Where appropriate, as a Care Act 2014 requirement, an independent advocate to represent and support the adult through a SAR.

• The timing of such notifications is crucial particularly where there are ongoing police investigations – this decision should be considered by the Board with the Police representative present.

• Involving the adult, family and friends can range from formal notification only, to inviting them to share their views with the Independent Author in writing or through interview.

• Be clear to the adult, family and friends who is likely to be involved in the whole process.

• Appoint a key contact, separate from the report author, for the adult, family and friends.

• Provide notification in a way that is appropriate to the individual case i.e. face to face or by letter. (see example letter in below).

• This should be accompanied by a plain English explanatory leaflet (see example below) that sets out the following:

• A description of the Board and its arrangements

• What is a Safeguarding Adults Review

• Why you are carrying out a Safeguarding Adults Review

• Who will carry out the review or how it will be completed if an independent author is not appointed

• What to expect during the review – what will they have to do

• What will happen after the report is finished

• How long the review will take

• The Board must put in place sufficient assurances that there is appropriate involvement in the review process of people affected by the case including where possible the person subject to abuse and their families/significant others.

• Updates must be given at key stages of the review and before the publication of the report. An appropriate person who is connected to the Board and the review must fulfil this role. It is advisable that this person becomes the key contact for the adult, family and friends for any questions and clarification during the process.

• Provide the adult, family and friends with contact details of people with the facility of asking questions, queries or clarifications through the process.

• Draft report shared with family by the IA or most appropriate person identified by the SARP. Detail how long the family will have to comment on the draft report.

• Ensure that the adult, family and friends are given details of how their personal information will be treated and how confidentiality will be adhered to. They must provide written consent to how this will be carried out.

• Where there are criminal investigations and family members are witnesses or suspects, the police senior investigating officer must understand the focus and scope of the review to help discussions about when and how family members can be involved.

Conclusion

• Put in place mechanisms to allow the adult and/or their family to feedback on the report before it is completed. (this may not result in significant changes)

• The key contact must arrange to meet up with the adult, family and friends to discuss the contents of the executive summary.

• Be clear on how families are to be represented in the final report.

• Provide the adult, family and friends a copy of the executive summary of the report. This will include the key findings and recommendations of the review

• Inform the adult, family and friends of next steps of how this will be presented and who will be involved.

• Be clear on how the report will be published and where it will be available.

• Explain that an action plan will be developed to respond to the recommendations made by the report and that its delivery will be overseen by the Safeguarding Adults Board.

• The Safeguarding Adults Board may wish to provide the adult, family and friends an update on progress against the action plan in agreed intervals

LETTER – Notification to Family Member or Friend

Date:

RE: XXXXXXX SAFEGUARDING ADULTS BOARD: SAFEGUARDING ADULTS REVIEW

(In the case of a death) First, I would like to offer my sincere condolences on the death of (adult’s name).

The purpose of this letter is to inform you that because of (insert circumstances) \*\*\*\*\*\*\*\*\*\*\*\*\* and the circumstances surrounding this. XXXXXX Safeguarding Adults Board (XSAB) will carry out something called a Safeguarding Adults Review.

Safeguarding Adults Boards have a duty to carry out a Safeguarding Adults Review (SAR) when an adult dies as a result of abuse or neglect. This is whether abuse or neglect is known or suspected, and there is information to suggest that partner agencies could learn lessons and improve the way they work together to support adults at risk in the future. A SAR may also take place when an adult has not died but it is known or suspected that they have suffered serious abuse, harm or neglect. The full criteria of a SAR are set out in the Care Act 2014. The purpose of a SAR is not to apportion blame. It is to identify recommendations to promote effective learning and improvement. This is in order to minimise the risk of future deaths or serious harm occurring again.

I would like to reassure you that this Safeguarding Adults Review will not influence any ongoing police investigations, or any work that may be happening at the moment between your family and professionals such as a social worker. This is a separate process, involving senior managers from all Health and Social Care Services, including the Police that make up the NYSAB.

Please do not hesitate to contact xxxxxxxxxxxxxxxxxx if you want to make some comments or observations to the Safeguarding Adults Review or if you would like any further information.

You may want to take independent legal advice before making any decisions about all of this. If your solicitor has any queries, he or she is also welcome to contact the above mentioned person.

Yours Sincerely

Copy To:

Independent Author



**Leaflets for Families Safeguarding Adults Reviews: Information for Families**

If you need this information in another format, please contact; NYSAB Safeguarding Adults Board Support Unit at nysab@northyorks.gov.uk or telephone 01609 780780

**What is NYSAB Safeguarding Adults Board?**

North Yorkshire Safeguarding Adults Board brings together all the main organisations who work with adults at risk and their families in North Yorkshire to keep them safe.

**What is a Safeguarding Adults Review?**

A Safeguarding Adults Review looks at how local organisations worked together to look after the adult at risk at the centre of the review. It may also look at how they are working with other adults with care and support needs in the immediate family or care settings. The review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is not a Criminal Investigation or Public Enquiry and its aim is not to place blame, but to learn.

**Why Are You Carrying Out A Safeguarding Adults Review?**

NYSAB Safeguarding Adults Board will carry out a SAR whenever an adult at risk has been seriously harmed or has died in circumstances where abuse or neglect is suspected or confirmed.

**Who Will Carry Out the Review?**

A panel of professionals from Community and Adult Care Services, the Health Service, the Police and sometimes other organisations are led by an independent person (the ‘Author’). They will meet to review reports from each organisation or agency which has worked with or provided services to the adult at risk or their family. The Independent Author will prepare a report. This report will say what lessons have been learnt and make recommendations for XXXXXX Safeguarding Adults Board.

**What Will Happen after the Report is Finished?**

NYSAB Safeguarding Adults Board will write an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. NYSAB Safeguarding Adults Board will make sure the actions are carried out and have a positive effect.

**What Will I / We Have To Do?**

You do not have to do anything. However, you will have the opportunity to give your views if you would like to. We will make sure that there is someone who can help you to do this (see contact details below).

**Who Will See the Report?**

Normally the Report will be kept confidential to those people who represent their organisations at NYSAB Safeguarding Adults Board or have contributed to the review and the staff within those organisations who worked with the adult at risk and their family. The Executive Summary sets out the key findings and recommendations of the review. It does not give any personal details or information which would identify the adult at risk, family or anyone else involved. It is available to anyone who wants to read it and will be on our web site. Your personal contact will meet with you and tell you what is in the Executive Summary before it goes on the website.

**How Long Will the Review Take?**

It usually takes six months from the start of the review to publication of the Executive Summary.

In this leaflet we have answered some of the most frequently asked questions families have about Safeguarding Adults Reviews. Of course, each case is different, and you may have other questions you would like to ask. If so, you can call your personal contact.

Your personal contact is (insert name)………………………………..

**LAR Sub-Group Terms of Reference**

The Board Manager and the Learning and Review Subgroup Chair will draft Terms of Reference for each Safeguarding Adult Review if using traditional methodology. These will be confirmed at the first meeting of the Safeguarding Adult Review Panel.

The purpose of the Review is to establish whether there are lessons to be learnt from the circumstances of the case about the way in which relevant professionals and agencies have or are working together to safeguard adults at risk to inform inter agency and multiagency practices as they relate to safeguarding adults at risk. The Terms of Reference will include:

1. Details of the person(s) subject to the Safeguarding Adult Review – name, date of birth, date of death (if relevant), address

2. Brief details of the concern that triggered the Safeguarding Adult Review

3. Specific areas of concern for the Safeguarding Adult Review to focus upon

4. Period of time the Safeguarding Adult Review is to consider

5. Agencies to provide Chronologies and Individual Management Reviews

6. Membership of Safeguarding Adult Review Panel – agencies, experts and specialists

7. Chair of the Safeguarding Adult Review Panel

8. Independent Overview Report Author

9. Arrangements regarding advocacy support (if appropriate)

10. Strategy for involvement of family members

11. Reference to any parallel investigations

12. Start and completion dates for the Safeguarding Adult Review

13. Key areas to be analysed

14. Strategy for implementation of lessons learnt

15. A strategy for publication of the Overview Report and Executive Summary

16. A strategy for managing media interest.