

**Safeguarding Adults Review Policy and Procedure**

**April 2024**

**Document information**

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| North Yorkshire Safeguarding Adults Board (NYSAB) | Susan Proctor  Independent Chair of NYSAB |
| Date procedures agreed by NYSAB | TBC |
| Date effective from | TBC |
| Date of next review | TBC |
| Target audience | All partner agencies represented by NYSAB and all other stakeholders |
| Related documents | Care Act 2014  Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews, April 2011 |

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**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 have been met. Partner agencies should not draw their own conclusions on whether the criteria are met, but should make a referral to Learning and Review Group (LAR) which is a subgroup of the North Yorkshire Safeguarding Adult Board (NYSAB).

1.3 All partner agencies have a responsibility to ensure that 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 considers 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:
* North Yorkshire Council (NYC) Health and Adult Services (HAS)
* North Yorkshire Police
* Humber and North Yorkshire Health and Care Partnership (ICB)
* Local NHS Trusts

1.6 The LAR will be considered quorate with representation from the three statutory agencies (police, Local Authority and Integrated Care Board) who are required to have suitably senior designated representatives.

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

1.8 The policy and practice undertaken by the NYSAB strives to reflect the SAR Quality Markers published by the Social Care Institute for Excellence (SCIE). A copy of the markers can be found here: <https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers>

# 2. Purpose

2.1 The SAR is a statutory learning-focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities.

2.2 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 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
  + lead to recommendations that are SMART (specific, measurable, achievable, relevant, time bound)

2.3 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

* 1. A SAR must be commissioned when:

1. an adult in the NYSAB area has care and support needs (whether or not the local authority was meeting any of those needs);

and

b1. either dies, and the NYSAB 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 adult died)

**Or**

b2. NYSAB knows or suspects that the adult has experienced serious abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

**and in both cases**

1. there is reasonable cause for concern about how the NYSAB, members of it (or other persons with relevant functions) worked together to safeguard the adult.
   1. The NYSAB has the power to undertake a discretionary 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.

3.3 Following a significant event, 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, or have appropriate mechanisms in place to be able to identify scenarios that require referring into the SAR process.

3.4 It is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (eg 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.

3.5 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 an organisation 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. This includes undertaking SARs.

3.6 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.

3.7 When considering a SAR referral, the LAR will need to establish if there is learning 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.

# 4. Section 44 Panel Meeting

4.1 Some cases may benefit from multi-agency discussion to decide whether a SAR referral is required. NYSAB holds a monthly S44 panel meeting, which provides a forum for multi-agency discussion between statutory partners, of serious cases or scenarios that do not necessarily fit the criteria for a s.42 duty enquiry or cases where there might be multi-agency learning. Meetings are held virtually on Microsoft Teams. At the panel, information is shared by partners in order to reach a consensus to either:

* Close the case with no further action required
* Escalate the case for consideration for a Safeguarding Adult Review

4.2 Core members of the group are:

* North Yorkshire Council: Safeguarding Adults Service Manager (or designated representative)
* North Yorkshire Police: Safeguarding Adults Manager
* Humber and North Yorkshire Health and Care Partnership/Integrated Care Board (North Yorkshire place): Designated Professional for Safeguarding Adults

4.3 Any professional can make a referral into the S44 panel meeting. There is no referral form as the process is designed to be quick and easy to access. Referrals are made via email to [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk), providing basic identifying information and a brief summary of the case. Referrals and cases are tracked on a central spreadsheet by the Review and Improvement Officer within Health and Adult Services.

4.4 The S44 panel provides updates on group activity to the LAR twice per year.

# 5. Making a SAR referral

5.1 Any agency representative, local councillors, Members of Parliament or professional MUST refer a case believed to meet the threshold of the criteria identified above in a timely manner, by completing the SAR Referral Form (Appendix 1) and submitting it to the LAR, using the NYSAB email address nysab@northyorks.gov.uk

5.2 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).

5.3 The LAR may choose to invite those making a referral in their professional role to present the case 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.

# 6. Making decisions on SAR requests

6.1 On receipt of a referral, the NYSAB Governance Team will (a) acknowledge the notification, (b) quality check the referral, and (c) advise the LAR Chair and NYSAB Independent Chair of the referral. If the mandatory criteria for a SAR appear to be met, approval will be sought from the NYSAB Independent Chair to proceed. Once approval is received, an Initial Chronology will be issued to each partner agency from the NYSAB Governance Team. The purpose of the Initial Chronology is to collect significant information to inform the discussion on whether the SAR criteria are met.

6.2 Where the SAR referral does not indicate the statutory criteria are met, the NYSAB Governance Team may ask the referrer to provide further information. If on receipt of further information, the SAR referral still appears inappropriate, a discussion will be held between representatives from the LAR to decide whether the recommendation should be to proceed, or to decline the referral. The discussion should, at the very least, involve representation from HAS, NY Police, and ICB. The decision will be communicated to the LAR Chair for approval, before the referrer is informed of the decision and the rationale for it.

6.3 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 paragraph 3.1 above. A SAR must be commissioned if there is a statutory requirement to do so.

6.4 A SAR referral will ordinarily be considered at the next available LAR meeting, or within ten working days of all initial chronologies being returned if possible. An extraordinary meeting will be arranged if the next LAR meeting is scheduled beyond this timescale.

6.5 Appropriate scrutiny should be held in relation to the Joint Chronology when determining whether the statutory criteria are met. If the SAR subject is still alive, consideration should be given to their views and experiences when determining whether they have suffered significant harm.

6.6 Consideration should be given to whether other quality assurance and feedback sources (eg audits/complaints) suggest the kind of practice issues in the referral are new, complex or repetitive. If any of the issues and the system conditions indicated in the referral are relevant to the SAB strategic plan, this will be escalated at the earliest opportunity.

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

6.8 The recommendation will be forwarded to the NYSAB Independent Chair for ratification. The referrer will be notified of the outcome by a member of the HAS Governance Team using Appendix 3.

6.9 If the LAR considers 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. In considering whether there are sufficient lessons to be learned and value in commissioning a Discretionary SAR, LAR will use the guidance shown in Appendix 4.

6.10 The LAR can make the following decisions where the statutory criteria for a SAR are NOT met:

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

6.11 The findings of any single or multi-agency review will be shared with the LAR once complete.

6.12 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 (eg Domestic Homicide Review [DHR], 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. For example, police investigations or an NHS Serious Incident review. If a person has died, the NYSAB Governance Team will contact the Coroner to identify whether an inquest has or will be held.

6.13 Should the referrer challenge the decision of the LAR, the Independent Chair of the NYSAB will respond. The decision can be re-visited if new information has come to light. 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.

6.14 The LAR is responsible for keeping a record of all cases that have been referred and considered for a SAR.

# 7. Undertaking a SAR

7.1 Once the decision has been made to instigate a SAR, the NYSAB Chair will write to the heads of agencies concerned advising advise them that a SAR will be carried out and asking them to nominate a senior member of staff to support the review process. See Appendix 5. Contact will be made with the Senior Investigating Officer from the relevant police force 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 (eg Safeguarding Enquiries or Serious Incident Reviews).

7.2 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. A Chair will also be appointed to lead the SARP.

7.3 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. Where there are concerns a person is unable to give consent, the principles of the Mental Capacity Act 2005 should be adhered to. If the person does not give consent, legal advice will be sought to help determine whether it is in the public interest to continue. See Appendix 6 for further details about consent. To ensure that the subject is fully supported in this process, consideration will be given to advocacy, either in the form of a suitable family member of friend, or an advocacy service made available via the Local Authority. Where there is involvement of the person and/or their family, in discussion with them, the LAR will agree how they and the interested party will be represented in the report.

7.4 The SARP will create the Terms of Reference. It should reflect the six safeguarding principles set out in the Care Act and NYSAB’s Multi-Agency Safeguarding Policy and Procedures. It should also specify the time period the SAR will cover. The Terms of Reference should be anonymised or consent should be sought if records are to include identifiable information.

7.5 The SARP should nominate and agree an individual within the SAB partnership to communicate with the family whilst the SAR is being undertaken. See Appendix 6 for further guidance. 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, explain the process and purpose, and inform them of their point of contact. This should be completed as soon as practically possible. 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.

7.6 The SARP should consider who will be consulted as part of the review, and document any reasons why certain family members/friends/others are excluded from contributing.

7.7 An Independent Author (IA) will be commissioned and this will be determined by the methodology employed to undertake the SAR.

7.8 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 arise during the process of the review the IA must declare this at the earliest opportunity to the SAR panel.

7.9 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 not be possible, the matter will be discussed at the LAR and with the NYSAB chair. Updates will be recorded in the minutes of the LAR meeting. Interested parties, such as the family, will be notified on the progress of the review.

7.10 The SARP will regularly meet during the SAR process to monitor progress and discuss whether any amendments to the Terms of Reference are required.

7.11 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.

7.12 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 should be acknowledged by the agency. The impact may be felt beyond the individual staff involved to the team, organisation or workplace.

7.13 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.

7.14 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, two weeks will be afforded to read the SAR and provide any response. However, extensions will be granted at the discretion of the NYSAB Independent Chair if deemed appropriate to do so.

# 8. Making a decision on SAR methodology

8.1 Once the LAR has agreed to commission a SAR, a SAR Panel will be convened that 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** **(SARP)** – 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 with appropriate skills, knowledge and experience (see below)
* **Terms of Reference** – compiled by the SARP and published as part of the review
* **Early discussions with the adult and their family, carers and representative** – 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**

8.2 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. The methodology should ensure that the principles of Making Safeguarding Personal and the six core adult safeguarding principles are embedded through the review.

8.3 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?
* Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
* What methodology is the most effective way to achieve the learning in the quickest timescales?
* Is a more appreciative approach required to review good practice?
* Are trained lead reviewers available in-house or nationally for the method selected?

# 9. Outcomes from SARs

9.1 The SAR report should make visible the systemic risks to single and multi-agency safeguarding work, in order to have practical value in directing improvement actions. It is written with a view to being published. Details of the person are included as judged necessary to illuminate the learning and/or in line with the wishes of the individual or their family.

9.2 The NYSAB must ensure that there is sufficient analysis, scrutiny and evaluation of evidence throughout the SAR process. Analysis assumes a systems approach to safety and organisational reliability. Conclusions are of practical value, evidencing the wider learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date.

9.3 The Independent 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 (GDPR) and other legal requirements.

9.4 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.

# 10. Implementation of Action from SARs

10.1 The NYSAB is responsible for ensuring any learning identified within the report has clear recommendations to action change. These recommendations MUST be SMART (Specific, Measurable, Achievable, Relevant and Time bound). Actions are integrated, where ever possible, with the wider strategic aims of the NYSAB.

10.2 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 that 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 meetings. 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

10.3 An action plan will be held by the LAR who will meet a minimum of four times a year to review and check progress on each action.

10.4 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.

10.5. For recommendations arising 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.

# 11. Communication of outcomes of SARs

11.1 Publication should be timely and publicise the key systemic risks identified through the SAR. Publication of the SAR will ordinarily be managed through the NYSAB website, but adapted as necessary for different audiences, including the public. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and others. A pseudonymised report will usually be published unless the NYSAB Independent Chair agrees there are exceptional circumstances not to do so. In such an event, an Executive Summary may be made available.

11.2 As North Yorkshire Heath and Adult Services are the lead agency for adult safeguarding, media and communication activity about the SAR will be co-ordinated by the North Yorkshire Council’s Communications Unit on behalf of the Board (and in collaboration with the communications teams of the other agencies involved). North Yorkshire 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.

11.3 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 a recommendation then it must state the reason for that decision in the annual report. The SAB maintains a public record of findings, actions and commentary to enable public accountability.

# 12. Dispute Resolution during SAR Process

12.1 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.

12.2 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 IA during the carrying out of a review. Any concern that cannot be resolved with be escalated to the NYSAB Independent Chair for a final decision.

(b) For disputes relating to the report content, the objecting party will provide written representation setting out their concerns to the IA within seven working days of being advised that the final draft report will not be amended.

(c) Where the NYSAB Independent Chair is unable to resolve the dispute, they may recommend to NYSAB that a reference to the dispute, and why it was not possible to resolve, should be included as an addendum to the report.

# 13. Safeguarding Adults Review Procedure

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|  | **Stage of Procedure** | **Role** | **Responsibility** | **Maximum Timeframe** |
| **1** | **Notification** | 1.1 Notifications for consideration of a Safeguarding Adults Review should be made to the NYSAB Business Unit using form Appendix 1  Upon receipt of a notification, the NYSAB Governance Team will:  a) Confirm receipt of the Referral Form  b) Screen the information received against the NYSAB SAR Policy and SAR Decision Support Guidance; and inform the NYSAB Chair if the criteria appear to be met  c) Inform the referrer if the criteria are not met following consultation with partner agencies and agreement with the LAR Chair | Referrer  NYSAB Governance Team | As soon as practically possible  Same day as the notification is received  As soon as practicably possible |
|  |  | 1. The **adult** and/or their representative will only be informed at this stage of the process if there *are exceptional circumstances.* The NYSAB Chair will have the final decision on what can be considered exceptional | NYSAB Governance Team on behalf of the NYSAB Chair |  |
|  |  | 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. The forms are returned to the NYSAB e-mail account | All partner agencies | As soon as practically possible |
|  |  | 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 |  |
|  |  | 1. Health and Adult Services, North Yorkshire Police, and ICB should be represented at the LAR/SAR Decision Making Meeting in addition to the referring agency | LAR | As soon as practically possible once all chronologies are returned |
| **2.** | **Decision Making** | 1. A Joint Chronology will be issued to LAR/SAR Decision Making Meeting attendees at least one week in advance | NYSAB Governance Team |  |
|  |  | 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. The information contained in the Joint Chronology should be considered by the group 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 | NYSAB Governance Team  LAR Chair/Group attendees | As soon as practically possible once all chronologies are returned |
|  |  | 1. The LAR should also take into account: 2. Whether any other Statutory Review or significant processes are taking place (Children’s SPR, police investigation etc.) 3. What potential impact a SAR may have upon such investigations or proceedings 4. 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. 5. 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 | As soon as practically possible once all chronologies are returned |
|  |  | 1. The NYSAB Independent Chair will be informed of the decision in writing using the SAR Decision Making document – Appendix 3 | NYSAB Governance Team | Within two working days of the LAR decision making meeting |
|  |  | 1. The referring agency/person to be informed of the decision. Partner agencies to be informed via Appendix 5 | NYSAB Governance Team | Within five days of the NYSAB Independent Chair’s ratification |
|  |  | 1. Any challenge to the decision should be made in writing to the NYSAB Governance Team or Chair of the LAR | NYSAB Governance Team | Within 28 days of notification |
|  |  | 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 | LAR Chair/LAR attendees |  |
|  |  | 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. 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 | Most appropriate person identified by the LAR | As soon as practically possible |
|  |  | 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’slife will be reviewed, taking into account the circumstances of the case | LAR attendees |  |
| **3.** | **SAR Panel (SARP)** | 1. The first SARP meeting will review the:  * Scope of the SAR * Determine the Terms of Reference * Recommend a methodology for the review. There is a range of methodology options for conducting Safeguarding Adults Reviews. See Appendix 4 * Arrangements for administrative support. * Identify a Chair | SARP attendees | Within 28 days of the SAR being initiated  Reasonably extended with the permission of the NYSAB Independent Chair |
|  |  | 1. In the event of any other Statutory Review processes (Children’s SPR, 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 | SARP | As required |
|  |  | 1. The SARP should also:  * Consider if there are any specific considerations around, equality and diversity * Consider how the review process should take account of previous lessons learned nationally, regionally and locally. * Consider if the SARP will need to obtain independent legal advice about any aspect of the review * Consider how matters concerning family and friends, the public and media should be managed * Ensure that any learning identified at an early stage of the process is shared and acted upon | SARP |  |
|  |  | 1. A point of contact should be identified for on-going 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. Consideration will be given to the possible benefits of advocacy | To be identified by the SARP |  |
| **4** | **Timescale for SAR Completion** | 1. The NYSAB will aim for completion of the SAR within six 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   During any delay every effort should be made to capture learning from the case and apply to future practice | NYSAB Independent Chair | Within six months of initiation |
|  |  | 1. The LAR will be notified on the progress of the SAR at each quarterly meeting | SARP Chair | On-going |
| **5** | **Reports** | 1. All reports should be pseudononsyed unless the person or their 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. See Appendix 6 | Independent Author |  |
|  |  | 1. The Independent Author should present the Final Report to agency Strategic Leads for agreement prior to publication. The agreed documents should then be forwarded to the NYSAB Independent Chair by the Governance Team | NYSAB Governance Team | On completion of final report |
|  |  | 1. The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the NYSAB. | Independent Chair |  |
|  |  | 1. Liaison should take place with the adult and/or their representative regarding the final report and allow for feedback | Nominated contact | Prior to publication |
|  |  | 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 | Nominated contact/NYSAB Governance Team |  |
| **6** | **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 | Independent Chair |  |
|  |  | 1. An Action Plan will be created to oversee the implementation of any recommendations/actions | LAR | Immediately prior to publication |
|  |  | 1. A reason should be given for any decision where the NYSAB decides not to implement a recommended action | LAR/NYSAB |  |
| **7** | **Publication of Reports** | 1. All Safeguarding Adults Reviews conducted within the year will be referenced within the North Yorkshire 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 | Annually |
|  |  | 1. The NYSAB will publish Safeguarding Adults Reviews together with the associated Delivery Report on its website | NYSAB Governance Team | As required |
| **8.** | **Monitoring** | 1. Arrangements for the monitoring of actions plans should be put in place as follows:   1. Individual agency action plans to be monitored by the agency concerned 2. Overall monitoring to be undertaken by the LAR 3. A report on the implementation of action plans across partnerships to be given to the NYSAB at an agreed frequency 4. Liaison to continue to take place with the adult and/or their representative as appropriate | LAR | Following creation of the plan and until all actions are completed. |
|  |  | 1. Family/representatives will be informed of progress against the action plan six months after publication of the SAR | LAR |  |



**Safeguarding Adults Review Referral Form**

North Yorkshire SAB considers every Safeguarding Adult Referral (SAR) referral based on whether it meets the criteria for a SAR.

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 all Sections (below) are met. Please select all that apply.**

|  |  |  |
| --- | --- | --- |
| **1.** | **An adult with care and support needs has either died or experienced significant harm** |  |
| **2.** | **Abuse or neglect is suspected to be a contributory factor to the death/significant harm** |  |
| **3.** | **There is reasonable cause for concern about how the NYSAB, members of it or other persons with relevant functions worked together to safeguard the adult** |  |

**Details of adult at risk:**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Brief Details of the Incident; please describe how the SAR criteria (see above) may be met.  If the person is alive, please describe the impact of the alleged abuse. | | | | | |
|  | | | | | |
| **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**  eg Serious Incidents, MAPPA, Domestic Homicide, Single Agency/Management Reviews, Children’s Safeguarding Practice Review, 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 Council

County Hall

Northallerton

DL7 8AD



**Safeguarding Adult Review – Initial Chronology**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Adult:** |  | **Personal Identifier (e.g. NHS number):** |  |
| **DOB:** |  | **Organisation** |  |
| **Last Known Address:** |  | **Name of Professional Completing Chronology** |  |

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.

**Please note, not all information held by agencies will be relevant to the context of the Safeguarding Adult Review referral. To avoid unfiltered ‘data dump’, we ask that agencies use professional judgement in determining whether the information they hold is relevant to the nature of the referral. Advice can be sought from the HAS Governance Team if unsure.**

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/Time of Meeting** |  |
| **Date of Birth** |  | **Date of Death** (if applicable) |  |

**Attendance**

|  |  |
| --- | --- |
| **Name** | **Organisation** |
|  |  |
|  |  |
|  |  |
|  |  |

***Please note this document should be completed in conjunction with the ‘SAFEGUARDING ADULTS REVIEW (SAR) Decision Support Guidance’ (Appendix 4).***

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

|  |  |  |
| --- | --- | --- |
| **1.Criteria** | **YES** | **NO** |
| An adult with care and support needs has died OR been seriously harmed |  |  |
| Abuse or neglect, whether known OR suspected, are believed to have been a factor |  |  |
| there is reasonable cause for concern about how the NYSAB, members of it or other persons with relevant functions worked together to safeguard the adult |  |  |
| **Rationale for Decision** | | |
|  | | |

**If YES to all 3, a recommendation for SAR to Independent Chair for decision-making.**

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Discretionary   SAR |  | Multi-agency  Review |  | Single Agency  Review |  | Other (describe below) | |  |
| Rationale for Decision | | | | | | | | |
|  | | | | | | | | |
| Agency responsible for feeding back outcome of review back to the LAR within six months | | | | | | |  | |

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

|  |  |  |
| --- | --- | --- |
| **Other Reviews or significant processes currently being undertaken**  (eg Serious Incident, Multi-Agency Public Protection Arrangements (MAPPA), Domestic Homicide Review, Single Agency/Management Reviews, Children’s Safeguarding Practice 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? (Is legal advice required?) | | |
|  | | |

|  |
| --- |
| Are there any other conflicts of interest or reasons to delay the commencement of the SAR? If Yes, please explain |
|  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signature of SAR subgroup 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 subgroup 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.

**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):

* an adult in the NYSAB area has needs for care and support (whether or not the local authority was meeting any of those needs).

and

* either dies, and the NYSAB 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 adult died)

Or

* does not die but the NYSAB knows or suspects that the adult has experienced significant harm.

and

* There are concerns about how agencies worked together to safeguard 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 attempted murder/murder |
| Domestic Abuse | • | Permanent harm or death due to a lack of response to alleged abuse  domestic abuse | * Honour based violence * Please also refer to other categories of abuse; physical, neglect and sexual * Female Genital Mutilation (FGM) |
| 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 Omission | • | 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 |  | * Grievous bodily harm/assault with or without weapons * Inexplicable fractures/injuries * Inappropriate restraint |
| 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 subgroup 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:

* The approach taken to review a case should be proportionate according to the scale and level of complexity of the issues being examined
* Reviews of serious cases should be led by individuals who are independent of the case under review
* 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
* 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
* The Board should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons, for example because of potential prejudice to related court proceedings.

**MENU OF OPTIONS FOR SAR METHODOLOGY**

The menu of SAR methodologies set out below includes the following five options:

A Systems analysis

B Learning together

C Significant incident learning process

D Significant event analysis/audit

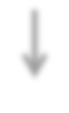
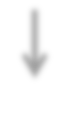
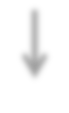
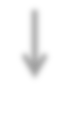
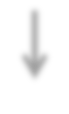
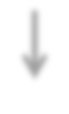
E Appreciative inquiry

On the following pages, a process map of each methodology is provided, along with key features and advantages and disadvantages to assist decision-making. Links are provided to identified available models, which can be used for the most part to download tools and guidance in order to conduct a SAR according to the methodology.

The menu is not an exhaustive list. The SAR Panel members should use its collective experience and knowledge to recommend the most appropriate learning method for the case (including hybrid approaches).

**Option A: Systems Analysis**

|  |  |
| --- | --- |
| **Key features** |  |
| * Team/investigator led * Staff/adult/family involved via interviews * No single agency management reports * Integrated chronology | * Looks at what happened and why,   and reflects on gaps in the system to identify areas for change |



Themes, solutions and achievable recommendations identified  SAR report

Order contributory factors by importance/impact

Analysis to identify contributory factors (service user/ team/management/systems/organisation conditions)

Identify Care/ Service Delivery Problems (specific actions/omissions/slips/lapses in judgement by staff/ volunteers)

Determine the chronology/ story of the incident

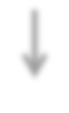
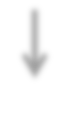
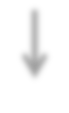
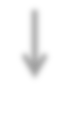
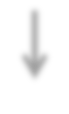
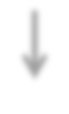
Identify and gather relevant data (eg documents, interviews, records, logs etc.)

Choose investigator-led or reviewing team-led model.

Agree interface with SAR panel.

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers may provide more balanced view * Managed approach to staff involvement may fit well where criminal proceedings are ongoing * Enables identification of multiple causes/contributory factors and multiple causes * Range of pre-existing analysis tools [available](http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) * Focusses on areas with greatest potential to cause future incidents * Based on thorough academic research and review * RCA tried and tested in healthcare and familiar to health sector SAPB   members. | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions * Staff/family involvement limited to contributing data, not to analysis * Potential for data inconsistency/ conflict, with no formal channel for clarification * Unfamiliar process to most SAPB members * Trained reviewers not widely available * Structured process may mean it’s not light-touch * RCA may be more suited to single events/incidents and not complex multi-agency issues |

**Option B: Learning Together**



Underlying system patterns identified and “challenges to the Board” (not recommendations)

Key practice episodes identified, and analysed to identify contributory factors

“Narrative of multi-agency perspectives” produced (not a chronology)

In depth discussion with case group (includes staff/adult/family)

Data and information gathered and reviewed, including via 1:1 conversations with staff/ family (not interviews)

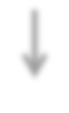
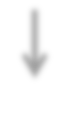
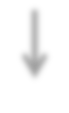
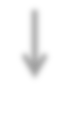
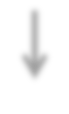
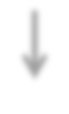
One or two lead reviewers, and a case group identified and prepared. Interface with SAR panel agreed

Research questions rather than fixed terms of eference are identified



|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers and case group may provide more balanced view * Staff and volunteers participate fully in case group to provide information and test findings * Enables identification of multiple causes/contributory factors and multiple causes * Tried and tested in children’s safeguarding * Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity * Range of pre-existing analysis tools available | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions * Challenge of managing the process with large numbers of professionals/ family involved * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses * Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR * Opportunity costs of professionals spending large amounts of time in meetings * Unfamiliar process to most SAPB members * Structured process may mean it’s not light-touch |

**Option C: Significant Incident Learning Process**



Final “recall day” to evaluate how effectively the learning has been implemented

Overview report finalised 

SAR report

“Recall day” convened to discuss emerging findings with staff/adult/family involved

Overview report drafted

“Learning day”, with front line staff/adult/ family, discusses the case based on shared written material

Data/materials gathered from individual agencies, through a management report

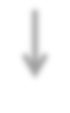
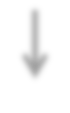
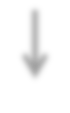
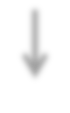
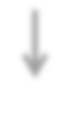
Review team identified and interface with SAR panel agreed

|  |  |
| --- | --- |
| **Key features** |  |
| * Team/investigator led * Staff/adult/family involved via interviews * No single agency management reports * Integrated chronology | * Multiple learning days over time * Explores the professionals’ view at the time of events, and analysis of what happened and why |

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Flexible process of reflection – may offer more scope for taking a light- touch approach * Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants * Has similarities to traditional SCR approach, so more familiar to most SAPB members * Agency management reports may better support single agency ownership of learning/actions * Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity | * Burden on individual agencies to produce management reports * Opportunity costs of professionals spending large amounts of time in learning days * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses * Not been widely tried or tested, nor gone through thorough academic research/review |

**Option D: Significant Event Analysis**

|  |  |
| --- | --- |
| **Key features** |  |
| * Team/investigator led * Staff/adult/family involved via interviews * No single agency management reports * Integrated chronology | * Multiple learning days over time * Explores the professionals’ view at the time of events, and analysis of what happened and why |



Workshop agreed actions written up by facilitator  SAR report

Workshop asks what happened, why, what’s the learning and what could be done differently

Facilitated workshop analyses data

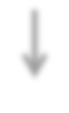
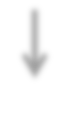
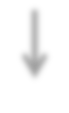
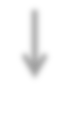
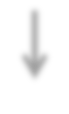
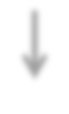
Factual information gathered from range of sources

Facilitator and panel of adult/family/staff involved in the case identified

Terms of reference/ objective agreed

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Light-touch and cost-effective approach * Yields learning quickly * Full contribution of learning from staff involved in the case * Shared ownership of learning * Reduced burden on individual agencies to produce management reports * May suit less complex or high-profile cases * Trained reviewers not required * Familiar to health colleagues | * Not designed to cope with complex cases * Lack of independent review team may undermine transparency * Speed of review may reduce opportunities for consideration * Not designed to involve the family * Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses |

**Option E: Appreciative Inquiry**



Recognition phase – each agency shares good practice internally and endorses practice highlighted from their agency

Strategy phase – whole panel meets to agree how to share the findings with the SAPB  SAR report

Report of discussion sent to manager of each contributing agency

Celebration phase – whole panel discussion to hear from practitioners on what works, including adult’s/family views

Meeting between facilitator and adult/family member to ascertain adult’s/family views

Discovery phase – appreciation of best work done and system conditions making innovative work possible

Terms of reference/objectives agreed. Panel of staff involved in the case identified and a facilitator

|  |  |
| --- | --- |
| **Key features** |  |
| * Panel led, with facilitator * Staff involved via panel. Adult/No family involved via meeting single * No chronology/management reports | * Aims to find out what went right and what works in the system, and identify changes to make so this happens more often |

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days * Staff who worked on the case are fully involved * Shared ownership of learning * Effective model for good practice cases * Some trained facilitators available * Well-researched and reviewed academic model * Model understood fairly widely | * Not designed to cope with ‘poor’ practice/systems ‘failure’ cases * Adult/family only involved via a meeting * Speed of review may reduce opportunities for consideration * Model not well developed or tested in safeguarding. |





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 submit documentation 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.

Considerations

• 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 Representative**



Date:

RE: XXXXXXX SAFEGUARDING ADULTS BOARD: SAFEGUARDING ADULTS REVIEW

(In the case of a death) Firstly, 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



**Leaflet 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](mailto: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 North Yorkshire 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)