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Second national analysis of safeguarding adult reviews

Final report: Stage 1 analysis

Case characteristics; nature of the abuse and neglect; SAR reviewing process

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Second national analysis of Safeguarding Adult Reviews

Introduction

This report presents findings from stage 1 of the second national analysis of Safeguarding Adult Reviews (SARs), drawing on quantitative data extracted from 652 reviews completed between April 2019 and March 2023. The findings from stage 1 cover the characteristics of the individuals whose circumstances are featured in the SARs, the types of abuse and neglect they experienced, and the ways in which the reviews were conducted. This report should be considered alongside the separate report from stage 2 of the project, which reports the in-depth learning and recommendations from a stratified sample of the SARs. A further separate report covers stage 3 of the analysis, drawing together conclusions and priorities for sector-led improvement,

A list of published SARs for every Safeguarding Adults Board (SAB), collated from SAB web pages and/or the national SAR library managed by the National Network for SAB chairs, was sent to every SAB chair and business manager, along with a request for any further published and unpublished reviews completed during the four-year period. Currently there are 136 Safeguarding Adults Boards in England. All 136 boards have responded to verify and/or add to their sample. This 100 per cent response rate represents an improvement on the 98 per cent response rate achieved for the first national SAR analysis in 2020.

These board responses have produced an overall sample of 652 SARs, a figure that includes 77 unpublished reviews provided by SABs in response to guarantees of anonymity and confidentiality. In addition, boards declined to release 23 unpublished reviews because of the sensitivity of the material, most often because the individual was still alive and/or that they or family members could be identified and had requested that their privacy be respected. The regional breakdown of the SARs included in the analyses is as follows:

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Number of reviews	47	34	144	17	108	130	61	54	57	652

The majority of the reviews available were full reports or detailed executive summaries, although in 36 cases a seven-minute briefing was the only document available. The task of collecting the material was made more challenging by the fact that, despite being an initiative welcomed by boards, the SAR library is incomplete and that some Boards only post reviews on their web pages for a limited time. The number of SARs identified by this detailed process is lower than figures published annually by NHS Digital, although the focus in this analysis on reviews completed during the period (rather than commissioned) may in part account for this.

Eight SABs appear not to have completed any SARs in the four-year period covered by this second national analysis. This should be an area for exploration as to use of referral pathways, referral triage decisions and understanding of the mandatory and discretionary criteria in section 44 of the Care Act 2014.

Analytic approach

Stage 1 data were collated using a survey screening tool that provided quantitative and category data describing the characteristics of the individuals whose circumstances were under review, the abuse and neglect they had experienced and the nature of the SAR process itself. The screening was managed using Smart Survey and a survey designed for the task of systematising data related to each SAR report.

Each entry using the data collection tool referred to a single SAR; however, each SAR could relate to multiple people. The 652 SARs in the analysis contained details relating to 861 individuals, who could have been subjected to multiple types of abuse/neglect in multiple locations. As such, throughout these analyses the totals vary where multiple items have been recorded.

Tables have primarily been used to display data summaries and sorted for ease of interpretation; however, in some cases where there are multiple variables or more complex data summaries, figures are given and labelled accordingly.

In most instances, data are split by geographic region of the board that commissioned or carried out the SAR. It should be noted that some regions have significantly fewer SARs than others and care should be taken in interpreting findings where sample sizes are low. A difference seen in the results for regions with small sample sizes is more likely to be due to chance compared to regions with larger numbers of reviews.

Data were further processed resulting in two table formats:

- table of individuals' data – This contains details of the 861 individuals, some of whom feature in the same SAR.
- table of reviews' data – This contains details of 652 individual SARs, including the type of review and methodology.

Conditional highlighting is used in many of the tables to assist with interpretation. Highlighting by columns is done in green (the higher the value per column, the darker the shade) and by row in red (the higher the value per row, the darker the shade). For example:

Column-wise formatting

	Column A	Column B
Row A	5	2
Row B	10	1
Row C	7	0

Row-wise formatting

	Column A	Column B	Column C
Row A	5	2	1
Row B	10	1	3
Row C	6	3	8

Data processing, cleaning and subsequent analysis and visualisation have been completed using the R programming language and Microsoft Excel.

Section 1: The individuals featured in the SARs

Each SAR can focus on multiple individuals. In total the 652 SARs in this analysis feature 861 individuals, although the total number of individuals affected by the abuse and neglect considered in the reviews exceeds this. While the majority of the SARs gave details of the individuals involved, ten SARs looked at abuse/ neglect affecting a large number of people without giving details of all who were affected. Examples include enquiries into residential/nursing care provision in single or multiple homes, care provided in a hospital or NHS treatment facility, modern slavery activity or homelessness. This means that at least 214 additional individuals were affected by abuse or neglect – a total of 1075 people. The analysis that follows reports only on the 861 people about whose circumstances details were provided in the SAR reports.

As well as reporting on the analysis of their characteristics and circumstances, this report draws comparisons with the first national analysis of SARs, carried out in 2020. The first national analysis covered SARs from only two years, which resulted in a smaller sample (263 individuals from 231 SARs).

Gender of individuals by region

Both national analyses have found slightly more males than females included in SARs overall, although in both cases there were regional variations. A small number of individuals were identified as non-binary or transgender, and in a few instances gender was not specified, although no rationale given for this exclusion.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Female	31	20	86	10	62	75	37	32	25	378
Male	24	20	89	7	63	91	41	45	43	423
Non-binary	0	0	0	0	0	1	0	0	0	1
Transgender	0	0	0	0	0	0	0	1	0	1
Not specified	5	0	14	0	2	21	7	3	6	58

Age group of individuals by region

In this second national analysis, the age groupings have been adapted, making direct comparisons with the first national analysis difficult. There is, however, a lower percentage of cases where age has not been specified: 22.08 per cent in this second analysis as against 29.00 per cent in the earlier analysis.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Young adult (18-24)	6	3	16	0	11	11	2	8	11	68 (7.9%)
Adult (25-35)	9	3	16	4	12	14	7	4	3	72 (8.4%)
Adult (36-40)	1	1	7	2	7	11	5	3	4	41 (4.8%)
Adult (41-50)	7	6	16	1	13	21	8	12	11	95 (11.0%)
Adult (51-60)	7	4	20	3	14	19	14	10	11	102 (11.9%)
Adult (61-70)	3	5	25	3	13	21	9	6	10	95 (11.0%)
Adult (71-80)	5	1	16	3	13	16	13	11	6	84 (9.8%)
Adult 81+	10	4	35	0	22	23	6	9	8	117 (13.6%)
Unspecified	12	13	38	1	22	52	21	18	10	187 (22%)

Beyond gender and age, other characteristics protected in the Equality Act 2010 are only rarely reported. As in the first national analysis, heterosexuality is rarely explicitly stated. Similarly, in most cases ethnicity was not recorded and there is very limited consideration of religion. Improvement priority 20 in the first national analysis recommended greater attention to the impact of protected characteristics. The evidence suggests that little progress has been made in this regard. This may well reflect an absence of attention being paid to these features of people's lives in practice. Yet without greater attention to protected characteristics, patterns within safeguarding are impossible to identify.

Ethnicity and nationality of individuals by region

Ethnicity was not specified in just over two thirds of cases. Where it was specified, individuals were most commonly described as White (just over a quarter of the overall number of individuals), with smaller numbers identified as Black, African, Caribbean, Black British, Asian or Asian British. Nationality was similarly neglected, missing in three quarters of all cases. Reports would occasionally contain hints – for example that the individual had requested a carer or practitioner of a particular nationality or ethnicity, but without exploring this aspect of practice. This again reflected a probable lack of specificity in practice. One individual was described merely as being 'from Europe', another as having mistakenly been identified as of one ethnic and national background throughout their contact with agencies, their true position having only emerged with their death.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
White	12	7	50	6	32	59	21	30	14	231 (26.8%)
Black/African/ Caribbean/Black British	1	2	21	0	2	3	1	0	1	31 (3.6%)
Asian/Asian British	0	0	4	0	3	3	0	0	1	11 (1.3%)
Multiple/mixed	0	0	3	0	0	0	0	0	0	3 (<1%)
Other	1	0	2	0	0	0	1	1	1	6 (<1%)
Not specified	46	31	109	11	90	123	62	50	57	579 (67.3%)

Where nationality was identified, the breakdown emerged as follows, with British being the most commonly noted nationality across all regions.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
British	7	6	36	6	21	34	14	16	10	150 (17.4%)
Poland	1	0	3	0	0	2	0	0	0	6 (<1%)

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
India	0	0	1	0	0	0	0	0	0	1 (<1%)
Republic of Ireland	1	0	6	0	0	1	1	0	0	9 (1%)
Italy	0	0	0	0	0	0	0	0	0	0
Romania	0	0	0	0	0	0	0	0	0	0
Portugal	0	0	0	0	0	0	0	0	0	0
Spain	0	0	0	0	0	0	0	0	0	0
Pakistan	0	0	0	0	0	0	0	0	0	0
Nigeria	0	0	0	0	0	0	0	0	0	0
USA	0	0	0	1	0	1	0	0	0	2 (<1%)
Lithuania	0	0	0	0	0	0	0	0	0	0
France	1	0	0	0	0	0	0	0	0	1 (<1%)
Germany	0	0	2	0	0	0	0	0	0	2 (<1%)
China	0	0	1	0	0	0	0	0	0	1 (<1%)
Hungary	0	0	0	0	0	0	0	0	0	0
South Africa	1	0	0	0	0	0	1	0	1	3 (<1%)
Netherlands	0	0	0	0	0	0	0	0	0	0
Other	1	0	10	0	7	6	4	1	4	33 (3.8%)
Not specified	48	34	130	10	99	144	65	64	59	653 (75.8%)

Religion group of individuals by region

Religion was a predominantly neglected characteristic, with the SAR giving no information in 95 per cent of cases. Christianity was the only religion specified in more than 1 per cent of cases. Reviews occasionally recorded information that hinted at religious belief – that the person had strong faith, or to whom they were praying - but without any further detail being given.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Christian	0	0	6	0	4	3	1	0	0	14 (1.6%)
Hindu	0	0	0	0	1	0	0	0	0	1 (<1%)
Muslim	1	0	0	0	1	3	1	0	0	6 (<1%)
Jewish	0	0	4	0	1	0	0	0	1	6 (<1%)
Sikh	0	0	1	0	0	1	0	0	0	2 (<1%)
Buddhist	0	0	0	0	0	0	0	0	0	0
No religion	0	0	3	0	0	0	0	1	2	6 (<1%)
Other	0	0	2	0	1	0	3	0	0	6 (<1%)
Not specified	59	40	173	17	119	181	80	80	71	820 (95.2%)

Sexual orientation of individuals by region

In 90 per cent of cases sexual orientation was not specified. Where it was, most people were described as heterosexual, with only 11 individuals identified as LGBTQI+.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Heterosexual	3	2	13	0	10	23	9	8	7	75 (8.7%)
LGBTQI+	0	0	3	0	2	4	0	1	1	11 (1.3%)
Not specified	57	38	173	17	115	161	76	72	66	775 (90%)

Health conditions of individuals by region

As in the first national analysis, the data reveal the wide range of physical and mental health conditions that were experienced by individuals whose stories were reviewed. Many individuals experienced multiple health conditions. Therefore, the totals in the table below add up to more than the total number of individuals.

Once again, mental health and chronic physical health conditions were the most noted. Between the two national analyses, the percentage of reviews featuring mental health has risen marginally from 70 per cent to 72 per cent whereas the figure for chronic physical health conditions has risen more markedly from 56 per cent to 63 per cent. The most noticeable change between the two national analyses features substance misuse, an increase from 28 per cent to 46 per cent of reviews. The figure for impaired mobility now stands at 27 per cent, a rise from 20 per cent, while the figure for impaired cognition fell from 30 per cent to 23 per cent. These figures alone demonstrate the range of services and disciplines that must be involved in adult safeguarding, and the complexities involved in preventing and/or protecting people from abuse and neglect, including self-neglect. In the table below, the percentages in the final column indicate the proportion of SARs in which each health condition featured.

Condition relating to	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire and Humber**	**All regions**
Acute physical health	14	10	55	4	17	55	11	18	17	201 (31%)
Chronic physical health	25	16	100	11	62	82	44	35	36	411 (63%)
Physical disability	2	3	12	1	15	11	1	10	4	59 (9%)
Learning disability	12	7	30	4	22	11	12	8	10	116 (18%)
Autistic spectrum	3	5	9	1	4	7	5	4	9	47 (7%)
Mental ill-health	30	26	97	10	67	105	50	48	36	469 (72%)
Sensory impairment	5	2	14	0	10	12	2	7	5	57 (9%)
Memory and cognition	14	3	32	2	34	34	8	15	10	152 (23%)
Substance misuse	18	15	57	9	45	74	29	38	18	303 (46%)
Impaired mobility	15	5	48	2	39	27	14	13	10	173 (27%)
Skin viability	10	5	30	0	21	21	10	6	8	111 (17%)
Diabetes	6	2	23	3	21	17	6	8	7	93 (14%)
Other	7	2	18	2	9	3	11	5	5	62 (10%)
Not specified	6	0	15	0	5	18	3	3	11	61 (9%)

Living arrangements of individuals by region

As in the first national analysis, the individuals featured in the SARs were most commonly living alone and/or living in group situations. This was consistent across regions. Figures for people living alone show a small increase between the two surveys, from 41 per cent to 47 per cent. By contrast the figures for those living in group situations reveal a decrease from 38 per cent to 31 per cent.

There has been a small rise in the number of reviews where the individual was street homeless, from 7 per cent to 10 per cent. Some individuals had more than one form of living arrangement. Therefore, the totals in the table below add up to more than the total number of individuals. The percentages in the final column indicate the proportion of SARs in which each particular living arrangement featured.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Living alone	19	11	73	3	40	78	38	24	20	306 (47%)
Living with partner	2	7	9	3	20	16	9	10	6	82 (13%)
Living with partner and children	3	0	6	0	4	4	4	0	2	23 (3%)
Living with child/children	2	4	15	1	8	10	4	3	2	49 (8%)
Living with parent	2	4	13	2	13	5	5	6	10	60 (9%)
Living with friend(s)	1	2	4	2	1	5	0	0	0	15 (2%)
Living with professional carer	0	0	0	0	2	1	0	0	1	4 (<1%)
Group (residential/nursing care)	10	3	41	2	16	34	9	7	10	132 (20%)
Group (supported living)	3	2	17	2	11	11	5	8	8	67 (10%)
Temporary accommodation	0	0	0	0	0	0	0	0	0	0 (0%)
Living as street homeless	5	0	13	3	15	8	3	13	8	68 (10%)
Other (please specify)	8	6	16	7	12	18	6	13	12	98 (15%)
Not specified	10	3	13	0	9	12	15	6	1	69 (10%)

Housing type of individuals featured in SARs by region

Over one third of SARs do not record detail about the type of accommodation in which people were living. The percentage of reviews where this detail is missing has remained constant at 39 per cent. Where type of accommodation is reported, in the first national analysis the most prevalent was residential care (31 per cent) followed by accommodation let by a social landlord (20 per cent). In this second national analysis, the order has been reversed with prevalence also reduced – accommodation let by a social landlord 18 per cent and residential care 16 per cent.

The major change has been in the number of cases involving individuals who were street homeless or living in hostels. The figure in the first national analysis was eight per cent. In this second national analysis, when the figures for street homelessness, temporary accommodation, supported lodgings and hostels are combined, the figure is 29 per cent.

In some cases, individuals had experienced multiple types of accommodation. Therefore, the totals in the table below add up to more than the total number of individuals. The percentages in the final column indicate the proportion of SARs in which each particular accommodation type featured.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Owner occupied	4	1	13	1	14	15	3	6	5	62 (10%)
Private landlord	1	0	8	1	6	5	3	0	2	26 (4%)
Social landlord (standard)	5	8	22	4	18	26	14	11	12	120 (18%)
Social landlord (sheltered)	0	1	10	1	1	10	7	3	0	33 (5%)
Residential care	10	2	29	1	11	28	6	8	11	106 (16%)
Nursing care	1	1	14	0	9	13	2	1	1	42 (6%)
Adult foster care	0	0	0	0	0	0	0	0	1	1 (<1%)
Supported lodgings	2	2	11	2	7	7	4	4	3	42 (6%)
Hostel	0	1	5	3	3	4	2	7	4	29 (4%)
Street homeless	5	1	15	4	12	10	3	13	7	70 (11%)

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Temporary accommodation	2	2	12	1	4	12	2	3	9	47 (7%)
Other	12	8	21	8	16	18	21	11	8	123 (19%)
Not stated	22	15	52	3	38	53	31	22	16	252 (39%)

Aspects of experience within the lives of the individuals

SARs are human stories. This second national analysis has for the first time collected data about specific experiences within people's lives, following lines of enquiry informed by knowledge of SARs that have highlighted the impact of moves between multiple areas and challenges facing individuals who are care-experienced.

Accommodation located in multiple local authorities

The number of SARs in which an individual was noted to have experienced moves across local authority boundaries was 76, just under 12 per cent.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Yes	5	2	25	3	16	10	6	3	6	76
No[1]	31	21	91	10	70	80	41	33	43	420
Unknown	11	11	28	4	22	40	14	18	8	156

Of the 76 cases, the majority of moves (59 per cent) involved a cross-border placement initiated by commissioners of

[1] The figure for 'No' includes SARs where it was not explicitly stated that the individual had experienced multiple local authority moves. 'No' therefore includes both individuals who had not experienced such moves and likely also some individuals who had experienced moves, but for whom this was not stated in the SAR.

a service or facility of which the individual had been in need. In a third of the cases the individual had travelled across boundaries of their own volition and in seven per cent, a third party (e.g. family) had been involved.

SARs featuring care-experienced individuals

In 60 (nine per cent) of the SARs, an individual was identified as being care-experienced as a child or young person. The data suggest increasing engagement by Safeguarding Adults Boards with outcomes for care-experienced young adults and raise the question of how transitional safeguarding practice is developing.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
SARs featuring care-experienced individuals	7	1	12	2	11	13	5	2	7	60
Percentage of all SARs	15%	3%	8%	12%	10%	10%	8%	4%	12%	9%

Section 2: Nature of the abuse / neglect experienced

Due to the complex nature of cases, multiple types of abuse and neglect can occur in a single review. The analysis shown below should be seen only as a top-level summary, to be expanded with the richer detail in stage 2's qualitative analysis of a sub-sample of reviews. Multiple abuse types can be logged per SAR and per individual featured. Therefore, the tables and figures below show higher totals than the 652 reviews or 861 individuals included in the analysis.

Nature of the abuse/neglect by age group

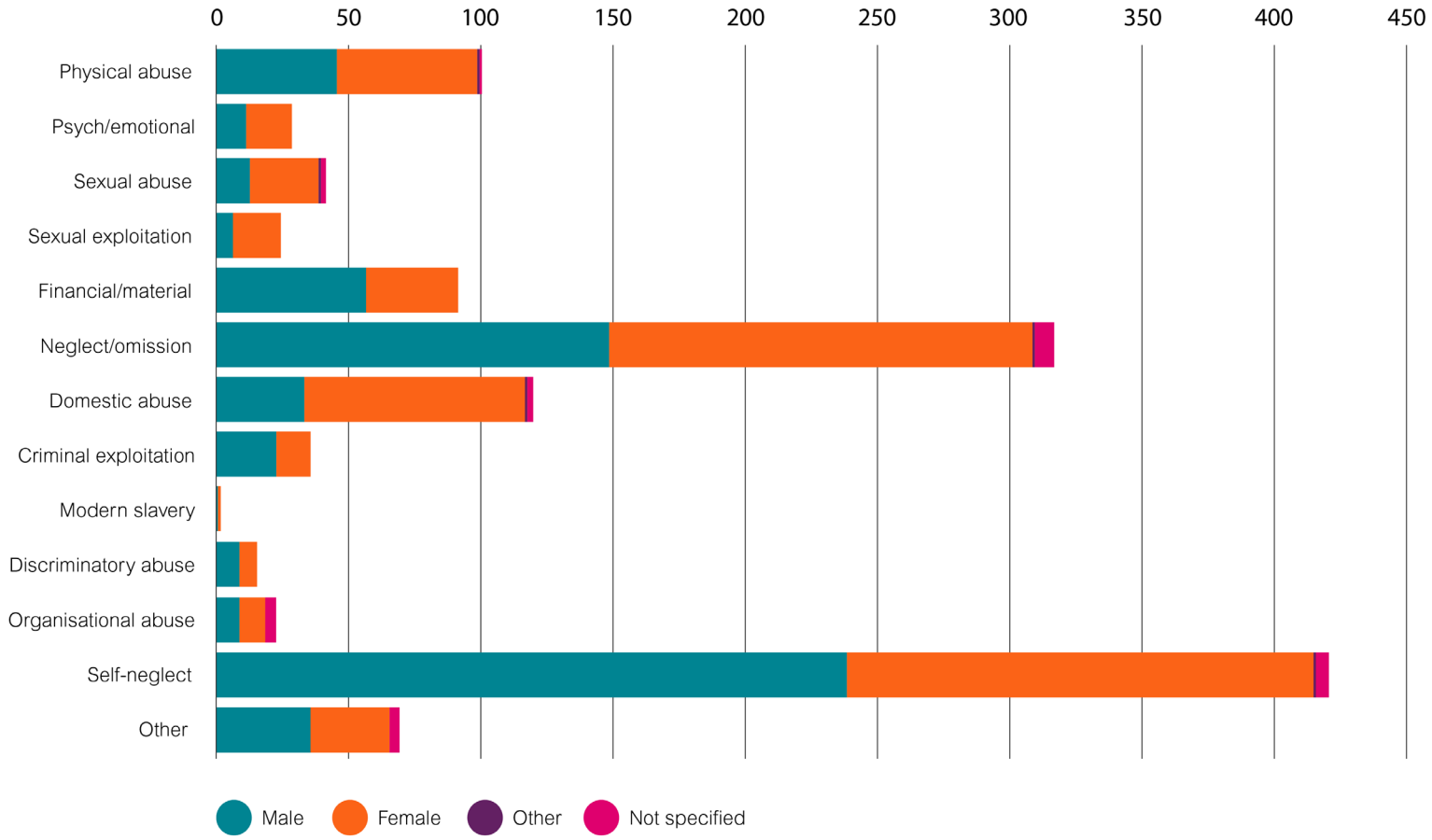
The table below shows the number of individuals within each age group experiencing each type of abuse/neglect. The final column shows the total across all age groups experiencing each type of abuse/neglect. The percentage given indicates what proportion of the 861 individuals were affected.

As in the first national analysis, the most commonly experienced type of abuse/neglect overall was 'self-neglect' (affecting 50 per cent of individuals featured in the SARs) followed by 'neglect/omission' (affecting 38 per cent). The table has been highlighted row-wise, showing how the most prominent age groups differ by type of abuse. For instance, modern slavery, sexual abuse, and sexual exploitation occurred more prevalently in younger individuals, whereas neglect and abuse by omission occurred more in those who were older, with the peak of self-neglect in the mid-years.

	Young adult (18-24)	Adult (25-35)	Adult (36-40)	Adult (41-50)	Adult (51-60)	Adult (61-70)	Adult (71-80)	Adult 81+	Unspecified	All ages
Physical abuse	8	11	8	15	7	10	9	15	15	98 (11%)
Psychological / emotional abuse	4	6	2	4	3	4	0	2	4	29 (3%)
Sexual abuse	14	10	3	7	2	1	1	3	4	45 (5%)
Sexual exploitation	11	5	1	2	1	2	1	1	3	27 (3%)
Financial/ material	6	9	9	14	22	14	9	11	10	104 (12%)
Neglect/ omission	33	23	12	26	38	38	47	62	46	325 (38%)

	Young adult (18-24)	Adult (25-35)	Adult (36-40)	Adult (41-50)	Adult (51-60)	Adult (61-70)	Adult (71-80)	Adult 81+	Unspecified	All ages
Domestic abuse	13	14	9	18	18	11	13	15	14	125 (15%)
Criminal exploitation	3	6	3	8	4	2	3	2	6	37 (4%)
Modern slavery	0	0	0	0	0	1	0	0	1	2 (<1%)
Discriminatory abuse	2	7	1	0	2	1	0	1	3	17 (2%)
Organisational abuse	1	5	2	0	0	1	2	4	8	23 (3%)
Self-neglect	30	49	11	65	78	65	49	38	51	436 (50%)
Other	17	7	3	9	11	8	3	6	13	77 (9%)

A gender breakdown of type of abuse shows those types that are more prevalent for certain genders. For instance, psychological / emotional abuse, domestic abuse and organisational abuse are more prevalent for females, whereas financial abuse and self-neglect are slightly more prevalent for males.



This bar chart shows the prevalence of each type of abuse and neglect in the SARs: self-neglect in over 400 cases; neglect/acts of omission in over 300 cases; domestic abuse in over 100 cases; physical abuse in 100 cases; financial/material abuse in almost 100 cases; psychological/emotional abuse, sexual abuse, sexual exploitation, criminal exploitation, discriminatory abuse, organisational abuse and modern slavery each in less than 50 cases. Other (unspecified) forms of abuse/neglect appeared in just over 50 cases.

Nature of the abuse/neglect recorded in SARs by region

The table below shows the number and the percentage of SARs in each region that featured each type of abuse and neglect. A review can feature multiple types of abuse/neglect; therefore the numbers exceed the total number of SARs. Each type of abuse/neglect is, however, counted just once per SAR even if more than one person was affected.

Comparison between the first and second national analyses shows a marked rise in both self-neglect (from featuring in 45 per cent of SARs to now featuring in 60 per cent) and neglect/acts of omission (rising from 37 per cent to 46 per cent). This was also the case at regional levels, except for the North-East region where 'domestic abuse' featured more prominently as the second most common.

Overall SARs focusing on domestic abuse have increased from 10 per cent to 16 per cent. There have been much smaller increases in reviews featuring discriminatory abuse (from one per cent to two per cent), sexual exploitation (from 2 per cent to 4 per cent) and sexual abuse (now 6 per cent). There has been no change in the prevalence of cases featuring financial abuse, but quite marked falls in SARs on physical abuse (from 19 per cent to 14 per cent), psychological abuse (from eight per cent to four per cent) and organisational abuse (14 per cent to four per cent). With respect to organisational abuse, the distinction between this and neglect/acts of omission can be difficult to draw. Stage 2 analysis of a stratified sample of SARs might help to explain this variation.

Type of abuse/neglect	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Physical abuse	13 (28%)	6 (18%)	12 (8%)	3 (18%)	11 (10%)	22 (17%)	8 (13%)	7 (13%)	7 (12%)	89 (14%)
Psychological/emotional abuse	2 (4%)	3 (9%)	7 (5%)	0 (0%)	5 (5%)	8 (6%)	1 (2%)	0 (0%)	1 (2%)	27 (4%)
Sexual abuse	6 (13%)	2 (6%)	3 (2%)	2 (12%)	10 (9%)	9 (7%)	4 (7%)	3 (6%)	1 (2%)	40 (6%)
Sexual exploitation	3 (6%)	1 (3%)	4 (3%)	1 (6%)	4 (4%)	2 (2%)	4 (7%)	1 (2%)	3 (5%)	23 (4%)

Type of abuse/neglect	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Financial/material abuse	6 (13%)	3 (9%)	19 (13%)	3 (18%)	13 (12%)	16 (12%)	10 (16%)	6 (11%)	7 (12%)	83 (13%)
Neglect/omission	22 (47%)	16 (47%)	76 (53%)	3 (18%)	52 (48%)	66 (51%)	16 (26%)	21 (39%)	27 (47%)	299 (46%)
Domestic abuse	7 (15%)	8 (24%)	18 (13%)	9 (53%)	16 (15%)	22 (17%)	10 (16%)	8 (15%)	9 (16%)	107 (16%)
Criminal exploitation	4 (9%)	3 (9%)	6 (4%)	1 (6%)	6 (6%)	5 (4%)	4 (7%)	2 (4%)	2 (4%)	33 (5%)
Modern slavery	0 (0%)	1 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Discriminatory abuse	3 (6%)	1 (3%)	4 (3%)	0 (0%)	3 (3%)	2 (2%)	1 (2%)	0 (0%)	2 (4%)	16 (2%)
Organisational abuse	3 (6%)	1 (3%)	5 (3%)	0 (0%)	2 (2%)	8 (6%)	3 (5%)	0 (0%)	2 (4%)	24 (4%)
Self-neglect	22 (47%)	19 (56%)	81 (56%)	14 (82%)	62 (57%)	85 (65%)	37 (61%)	36 (67%)	34 (60%)	390 (60%)
Other	5 (11%)	2 (6%)	18 (13%)	1 (6%)	4 (4%)	16 (12%)	12 (20%)	4 (7%)	3 (5%)	65 (10%)

Multiple abuse types can be logged per case. The table below show the range of abuse factors recorded per case. The mean average across the regions is 1.84, with a standard deviation of 1.09.

Standard deviation measures how dispersed a dataset is relative to its mean. The more spread out the data points relative to the mean, the higher the standard deviation.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber
Average number of types of abuse per SAR	2.04	1.94	1.76	2.18	1.74	2.01	1.80	1.63	1.72

Comparing SARs with section 42 enquiry data

There are 652 reviews in the dataset, across the nine regions of England. This can be compared with the number of enquiries undertaken under section 42, Care Act 2014, across the same regional areas. Using regional population data, a normalised comparison can be drawn between the section 42 enquiries and the SARs completed per 100,000 people in the population. This highlights areas such as Greater London, the South East and North West, where there are a higher number of SARs per 100,000 than elsewhere in the country. A Spearman's Rho analysis[2] of the ranked data shows that there is no correlation between the two groups ($p = 0.487$), indicating that the population-normalised regional prevalence of SARs does not correlate with the prevalence of section 42 enquiries. This may be unsurprising, but it nevertheless demonstrates also the differing regional variations in both the statutory investigation of abuse and neglect and the conduct of SARs. So, for example, Greater London per 100,000 population has the second lowest prevalence of section 42 enquiries but the highest prevalence of SARs. The North East per 100,000 population has the highest prevalence of section 42 enquiries but the lowest prevalence of SARs.

Region	Number of Section 42	Number of SARs	Regional population	Section 42 per 100,000	SARs per 100,000
East	16,055	47	6,348,096	252.91	0.74
East Midlands	12,800	34	4,880,094	262.29	0.70
Greater London	15,315	144	8,796,628	174.10	1.64
North East	17,263	17	2,646,772	652.23	0.64

[2] Spearman's Rho analysis (or Spearman's rank) is a non-parametric measure of correlation between two ranked lists of data. If the two lists are ranked exactly the same, there is a perfect correlation. The correlation strength is denoted by the r value ($r = 1$ is a perfect positive correlation), and the statistical significance is denoted by the p-value (if $p < 0.05$, the r value is statistically significant). No correlation ($p > 0.05$) indicates that the two lists are likely independent of each other.

Region	Number of Section 42	Number of SARs	Regional population	Section 42 per 100,000	SARs per 100,000
North West	24,818	108	7,422,295	334.37	1.46
South East	30,805	130	9,294,023	331.45	1.40
South West	13,755	61	5,712,840	240.77	1.07
West Midlands	10,345	54	5,954,240	173.74	0.91
Yorkshire and Humber	20,768	57	5,481,431	378.88	1.04

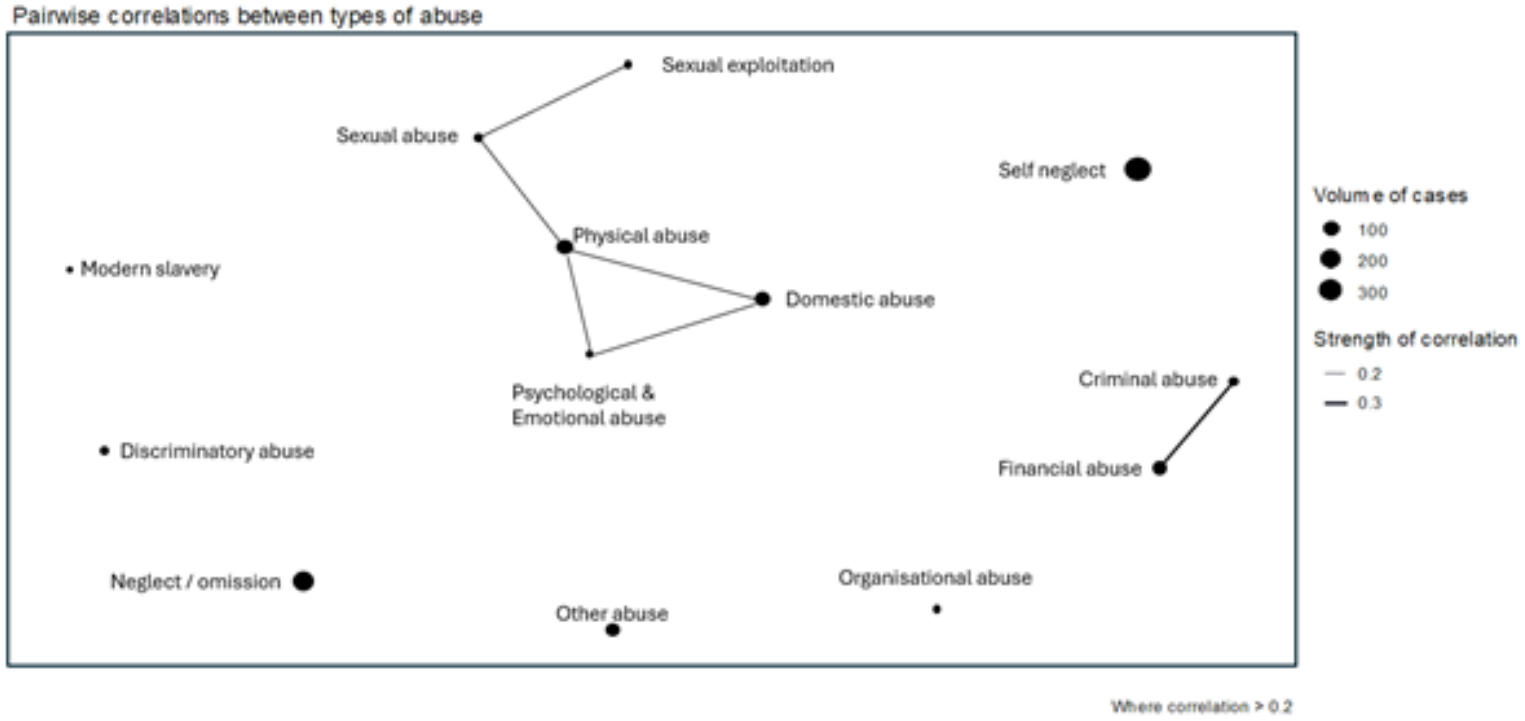
*S42 data average of 2019-20 and 21-22 data

Correlation between types of abuse

More than one type of abuse and neglect can be present in any individual case, and some types of abuse and neglect are more likely to co-occur than others. Correlations can be positive (types of abuse and neglect consistently recorded together), moderate (types that may co-occur), or negative (types that generally do not co-occur). Thus physical abuse moderately clusters with both psychological/emotional abuse and domestic abuse, while sexual abuse tends to co-occur with sexual exploitation and financial abuse with criminal exploitation. Conversely, self-neglect negatively correlates with neglect/omission, making them least likely to coincide among all abuse types (or possibly that in the presence of self-neglect, acts of neglect/omission by others are not seen as such).

The figure below shows correlations between types of abuse as a line between two points. The stronger lines show stronger correlations, and the size of the points indicates how prevalent each type of abuse is in the dataset. Highlighting groupings of abuse types more likely to be found together assists practitioners to identify ‘case types’, where the presence of one form of abuse and neglect would alert to the need for professional curiosity about other possible features of abuse also. Conversely, some types of abuse appear unrelated to all other types, such as self-neglect, and neglect and omission. That is not to say they are the only types of abuse recorded on cases, but that

they do not consistently occur alongside other types of abuse. This diagram, therefore, shows how types of abuse/neglect may cluster together. Physical, sexual, domestic and psychological abuse may occur alongside each other; financial abuse may occur alongside criminal exploitation. There was no correlation between other forms of abuse/neglect, which are therefore likely to be more commonly found in isolation.



Some reviews, however, do not clearly specify the types of abuse and/or neglect that are in scope in the case under review. The numbers of reviews in which the type of abuse or neglect is either not referred to at all or is only implied together account for almost one third of all reviews.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Abuse/neglect named	30	18	84	14	83	92	47	37	40	445 (68%)
Implied but not named	10	9	27	2	13	22	7	9	12	111 (17%)
Not named	7	7	33	1	12	16	7	8	5	96 (15%)

Perpetrator of the abuse/neglect by region

Across all regions the most prevalent perpetrator type was “self”, which reflects the high number of self-neglect cases and corresponds closely with a finding in the first national analysis. More than one perpetrator type could be named in each SAR, so the figures below exceed the number of SARs. The final column percentages indicate the proportion of SARs in which each perpetrator type features.

Comparison of the percentages between the first and second national analyses identifies a rise in cases featuring partners / relatives / friends / unpaid carers from 19 per cent to 25 per cent, endorsing the recent policy emphasis on safe care at home. Perpetrators classed as ‘other professionals’ (all practitioners apart from care workers or care provider agencies) have increased from 12 per cent to 28 per cent and there was a marginal increase in cases involving social contacts as perpetrators (from 9 per cent to 11 per cent). However, there was a small decrease in the frequency with which care workers / care providers were identified as the perpetrator (down from 30 per cent to 28 per cent).

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Partner/relative/friend/carer	12	10	26	8	26	36	14	14	20	166 (25%)
Social contact/acquaintance	10	6	9	2	10	16	8	6	4	71 (11%)
Care provider	20	6	52	3	28	38	14	11	9	181 (28%)

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Other professional	20	9	42	3	36	41	7	14	13	185 (28%)
Unknown to individual	5	1	3	1	6	4	2	1	1	24 (4%)
Self	24	21	99	15	75	116	49	57	37	493 (76%)
Not specified	8	1	18	1	8	1	12	2	10	61 (9%)
Other	6	4	9	0	4	22	9	3	8	65 (10%)

As well as looking individually and regionally at the nature of abuse, variables can be combined. The tables below show the relationships between abuse, perpetrator and location. The red formatting shows the highest frequency cells per row. For instance, in the first table, the formatting shows that where abuse is physical, the most likely perpetrators are partners (and relatives / friends), self, or social contacts. Looking down the column shows that partner / relatives / friends were also perpetrators in many other types of abuse/neglect, although a common perpetrator across all types is self (related to self-neglect cases).

	Partner/relative / friend/unpaid carer	Social contact or acquaintance	Care provider	Other professional	Unknown to individual	Self	Not specified	Other
Physical abuse	41	22	16	13	14	33	3	12
Psychological/ emotional	14	7	4	1	0	10	0	2
Sexual abuse	18	19	4	5	5	19	7	7
Sexual exploitation	11	12	0	3	4	14	4	4
Financial/material	33	36	9	9	8	58	3	7
Neglect/omission	77	18	124	158	9	121	10	25
Domestic abuse	83	15	0	9	5	62	7	4
Criminal exploitation	8	24	3	8	5	25	2	3
Modern slavery	0	1	0	0	0	0	0	0
Discriminatory abuse	3	3	7	5	3	10	1	1

	Partner/relative / friend/unpaid carer	Social contact or acquaintance	Care provider	Other professional	Unknown to individual	Self	Not specified	Other
Organisational abuse	0	1	19	7	2	1	0	2
Self-neglect	83	45	35	67	17	369	14	16
Other	11	8	7	7	1	29	16	17

The table below reports the number and percentage of cases where individuals were recorded as both victim and perpetrator of abuse, a situation that brings an added complexity to adult safeguarding.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
SARs where an individual was both victim and perpetrator of abuse	4	5	11	3	9	13	6	6	6	60
Percentage of SARs	9%	15%	8%	18%	8%	10%	10%	11%	11%	9%

Characteristics of the abuse or neglect by region

The following table presents the data on specific key areas of interest that were included in the specification set for this analysis. These related to (i) safe care at home, (ii) organisational abuse and closed environments and (iii) 'edge of care' themes (which include discriminatory abuse, transitional safeguarding, homelessness, adult exploitation, substance misuse, modern slavery, forced marriage, county lines, radicalisation and detention centres).

Of these areas of special interest, the most commonly featured in the SARs are substance misuse (featuring in 33 per cent of SARS) and abuse/neglect at home by paid/unpaid/volunteer carers (featuring in 23 per cent of SARs).

A direct comparison with data from the first national analysis is not possible across all categories. However, in the first national analysis 11 per cent of cases featured homelessness, whereas the table below identifies 13 per cent, highlighting perhaps a slightly increasing engagement by Safeguarding Adults Boards with homelessness. In the first

national analysis 25 per cent of cases featured alcohol dependency, whereas the table below records 33 per cent featuring substance use, often linked with self-neglect. There has been a slight increase in cases featuring transitional safeguarding (from three per cent to seven per cent). There was negligible focus on powers of entry in the first national analysis but five per cent of reviews in this second national analysis have recorded the use of existing powers of entry, concerns about their use and/or a need for a specific adult safeguarding power of entry.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Abuse/neglect at home *	13	6	31	4	26	29	14	12	16	151 (23%)
Use of/need for powers of entry	2	2	8	1	5	6	1	3	4	32 (5%)
Closed environment **	3	1	2	0	2	1	2	0	3	14 (2%)
Transitional safeguarding	5	2	9	1	7	5	2	4	10	45 (7%)
Homelessness	4	4	19	4	14	22	7	9	5	88 (13%)
Exploitation	6	3	10	3	14	14	8	4	8	70 (11%)
Substance use	15	14	41	9	28	48	23	20	18	216 (33%)
Forced marriage	0	0	1	0	7	0	0	2	1	11 (2%)
County lines	1	0	1	0	0	0	0	0	2	4 (<1%)
Radicalisation	0	0	0	0	0	0	0	0	0	0 (0%)
Detention centres	0	0	0	0	0	0	0	0	0	0 (0%)

* by paid/unpaid/volunteer carers

** closed door policies, seclusion, and/or segregation

Location of the abuse/neglect by region

Individuals experienced abuse and/or neglect most commonly in their own home, which fits with the finding that self-neglect was the most common type of abuse/neglect in reviews. The figures for care/nursing homes, supported living and other accommodation also fit with neglect/acts of omission being the second most recorded type of

abuse/neglect. There will be overlaps here with reported and possibly unreported organisational abuse.

As with types of abuse/neglect, multiple locations can be recorded, so the figures below exceed the number of SARs. The final column percentages indicate the proportion of SARs in which each location features.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Own home – general	15	11	72	6	47	62	27	19	30	289 (44%)
Own home – sheltered	0	0	8	2	1	8	4	3	0	26 (4%)
Someone else's home	4	1	4	1	8	7	4	1	1	31 (5%)
Supported living	3	2	12	2	11	10	6	3	5	54 (8%)
Hostel/shelter	0	1	7	2	2	5	3	8	1	29 (4%)
Temporary housing	1	2	10	2	5	9	1	4	2	36 (6%)
Service (for example, day centre)	0	0	2	0	1	2	0	0	0	5 (<1%)
Community (for example, street)	6	6	13	2	13	18	1	19	2	80 (12%)
Care/nursing home	9	3	32	2	17	32	14	7	13	129 (20%)
Hospital	14	2	12	3	11	5	3	3	5	58 (9%)
Prison	0	0	0	0	0	1	0	0	0	1 (<1%)
Own home - unspecified	11	14	29	4	29	24	19	16	12	158 (24%)
Not specified	4	7	9	1	5	18	4	16	7	71 (11%)
Other	10	1	11	0	6	13	15	2	9	67 (10%)

The relationship between location and type of abuse/neglect highlights that the individual's own home was the location in the majority of cases and across most types of abuse. In the table below, the row-wise highlighting shows the most

prevalent locations for different abuse types. For instance, abuse by neglect and omission primarily occurred at home, but there were also cases in hospitals and care homes. Sexual abuse was not grouped around specific locations.

	Own home – general housing	Own home – sheltered housing	Someone else's home	Supported living	Hostel/ shelter	Temporary housing	Community service (e.g. day centre)	Community (e.g. on the street)	Care/ nursing home	Hospital	Prison	Own home, type not specified	Not specified	Other
Physical abuse	27	2	8	12	4	5	0	12	17	6	0	21	1	6
Psych/ emotional	13	0	3	2	2	4	0	3	5	0	0	4	1	3
Sexual abuse	8	0	9	5	1	2	0	7	5	4	0	9	7	5
Sexual exploitation	7	0	6	1	1	2	0	6	0	1	0	2	6	5
Financial/ material	56	5	7	5	6	5	0	18	4	2	0	8	2	5
Neglect/ omission	87	13	15	24	8	7	5	16	67	39	1	75	7	20
Domestic abuse	51	2	10	4	4	9	0	11	1	5	0	27	8	11
Criminal exploitation	18	1	6	3	2	2	0	6	1	2	0	9	2	2
Modern slavery	0	0	0	0	0	0	0	1	0	0	0	1	0	1
Discriminatory abuse	5	0	0	5	1	3	0	2	4	4	0	2	0	0
Organisational abuse	1	0	0	2	0	0	1	0	16	3	0	1	0	0
Self-neglect	195	18	19	26	21	29	1	46	19	22	1	84	16	24
Other	17	1	2	7	2	5	0	3	4	2	0	7	17	11

Resident on resident abuse

One specific feature relating to location of abuse/neglect is reported in the table below, namely resident on resident abuse. This is the first time this data has been collected. Its relevance is reinforced by answers to a question that SABs were asked for this analysis, namely whether there were reviews that in their view had regional and/or national significance. One commonly named SAR as having national significance features resident on resident abuse. SAR Eileen Dean published by Lewisham Safeguarding Adults Board; Eileen was murdered by another resident.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
n resident on resident abuse	6	4	3	1	5	11	1	2	4	37
Percentage of SARs	13%	12%	2%	6%	5%	8%	2%	4%	7%	6%

Outcomes for individuals by region

In the majority of cases (82 per cent), the individual or individuals featuring in the SAR were deceased at the time of review. In SARs featuring multiple individuals, 'alive' and 'deceased' may both have been recorded. Some SARs, however, did not specify whether an individual died or survived. Implicit within the data remains a question asked also in the first national analysis, namely how SABs are seeking assurance about learning from cases where adults have survived abuse/neglect. The percentages in the final column show what proportion of the 861 individuals were within each category.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Alive	9	10	19	0	21	19	12	15	8	113 (13%)
Deceased	45	30	160	17	105	156	64	65	63	705 (82%)
Not specified	6	0	10	0	1	13	9	1	3	43 (5%)

Cause of death

Of the 705 people who were deceased, the majority had died as a result of natural causes. Suicide accounted for 15 per cent of deaths, a marked increase compared with the first national analysis (seven per cent). This increase might in reality have been even higher as at times it was unclear whether a death was accidental or the result of suicide, the circumstances indicating that it could have been either. Comparison also reveals decreases in the prevalence of fire deaths (five per cent as against eight per cent) and homicides (three per cent as against five per cent). The 59 cases (eight per cent) in which cause of death was 'unspecified' relate to reviews in which it was stated that the individual was deceased but the cause of death remained unclear or was not given in the review. The 26 (four per cent) cases of death 'unascertained' relate to coroners' verdicts. The numbers in the table exceed the 705 people who were deceased, as at times multiple causes of death were apparent, for example, an individual dying in a fire they had deliberately started, counted as both fire and suicide. The percentages show in what proportion of the 705 cases each cause was apparent.

Natural causes	404	57%
Suicide / self-inflicted	106	15%
Accident	65	9%
Unspecified	59	8%
Fire	36	5%
Unascertained	26	4%
Homicide	23	3%
Unknown	20	3%

Section 3: Nature of the reviews

This section provides information about the conduct of the SARs: the type of reviews undertaken, who was involved, timescales and other features of the review process.

Type of abuse by legal mandate of the SAR

The majority of reports were explicit that the SAR was conducted under the legal mandate contained in section 44 of the Care Act 2014. This was stated in 77 per cent of cases. In almost half of those cases, however, it was not clear whether the SAR was undertaken under the mandatory duty (section 44(1-3) or the discretionary power (s.44.4). It was not uncommon to find part or all of section 44 quoted without precisely stating whether or not the SAR referral was judged to have met the mandatory criteria or the SAB was exercising its discretion. In some cases, where a review featured several individuals, the mandate might vary with each individual – some having met the mandatory criteria and others included using the discretionary mandate.Not all SABs and SAR authors appear yet to have grasped the distinction between the two mandates contained within the statute. There were references to a review being 'non-statutory' or generic descriptions of referrals "not meeting the criteria" or "the threshold" for a statutory SAR, with a review nonetheless conducted. These were sometimes termed 'learning reviews' but would more accurately be described as discretionary SARs. They are still statutory in that the mandate for conducting them lies within the Care Act and indeed SABs have no powers to conduct reviews other than those conferred by section 44. It is therefore not clear what would have been the 'other' mandate noted in a small number (three per cent) of the SARs. Greater precision is needed in order to ensure that decision-making is defensible if ever challenged.

Legal Mandate	Reviews	Per cent
Statutory (s.44, 1-3) - mandatory	189	29%
Statutory (s.44, 4) - discretionary	88	14%
Statutory (not stated whether mandatory/discretionary)	220	34%
Other	22	3%
Not specified	133	20%

Type of review by region

The types of review carried out were comparable to those in the first national analysis; most SARs continue to be standard reviews of one individual's circumstances (83 per cent, compared to 78 per cent previously). Thematic reviews, which typically review the circumstances of multiple individuals, formed eight per cent.

Type of review	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Standard SAR	85%	94%	81%	76%	88%	83%	70%	85%	83%	83%
Thematic review	9%	6%	11%	0%	4%	9%	13%	11%	5%	8%
Learning review	2%	0%	1%	18%	1%	1%	7%	0%	7%	2%
Other	4%	0%	8%	6%	7%	7%	10%	4%	5%	6%

In a small number of cases, the SAR was being undertaken jointly with a Domestic Homicide Review or a Mental Health Homicide Review, with the report covering both types of learning.

Approaches taken to the SAR process

The most common approach taken to the SAR process is a hybrid approach in which analysis of documents (such as chronologies and reflective reports) is accompanied by learning events or meetings with key informants. This accounts for 48 per cent of all SARs, mirroring the first national analysis. Analysis of documents alone accounts for a further 18 per cent. In 16 per cent of reviews, however, the approach taken is not specified. This too mirrors a finding from the first national analysis.

Description	Reviews	Per cent
Document-based (chronologies and IMRs)	118	18%
Hybrid (e documents and learning event/discussion)	312	48%

Description	Reviews	Per cent
Review in Rapid Time	22	3%
SCIE Learning Together	24	4%
SILP	1	<1%
Welsh model	13	2%
Other	56	9%
Not stated	106	16%

Examples of 'other' approaches include: multi-agency audit focusing on new policies, processes and commissioned services developed since the person's death; a single practitioner event; an additional element added to previous SARs undertaken by the SAB or to reviews of the case undertaken within single agencies; desktop review session; a one-day review of information requested of agencies in relation to targeted questions; questionnaires completed by people in similar circumstances to the individuals under review; literature review of SARs undertaken in similar circumstances; significant event analysis; signs of safety review. In every region also, hybrid approaches are most commonly used.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Document-based	9	7	28	1	12	36	10	7	8	118
Hybrid	22	20	69	9	56	50	25	27	34	312
Rapid review	3	1	6	2	5	3	1	0	1	22
SCIE	1	0	9	1	6	6	1	0	0	24
SILP	0	0	0	0	0	0	0	1	0	1
Welsh	0	0	0	0	12	0	0	0	1	13
Other	3	1	9	0	5	19	9	4	6	56
Not stated	9	5	23	4	12	16	15	15	7	106

Source of SAR referral by region

The source of the SAR referral to the Safeguarding Adults Board was frequently not specified, as was the case in the first national analysis. In that analysis 68 per cent of SARs did not identify the source of the referral. Here the figure has risen to 75 per cent. Although individual Safeguarding Adults Boards would be expected to monitor and take appropriate action regarding local referral patterns, the lack of clarity here makes it difficult to identify patterns regionally and nationally. Of the remainder where sources were given, the most common SAR referring agency was the local authority, with the Police and hospital trusts also active as referring agencies. The 'other' sources in the table below include small numbers of referrals from coroners, integrated partnership trusts, LeDeR processes, the CPS and family members.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Local authority	1	1	23	1	7	15	6	3	4	61
Police	0	0	3	0	6	8	2	2	4	25
CCG	0	0	2	0	2	0	0	0	0	4
Ambulance service	0	0	0	0	0	1	0	0	0	1
Fire & Rescue service	0	0	1	0	0	3	0	1	1	6
GP surgery	0	0	0	0	0	1	3	0	0	4
Community health trust	0	0	0	0	0	1	0	0	0	1
Hospital trust	0	2	5	1	2	4	1	0	2	17
Mental health trust	1	0	0	0	1	3	3	1	2	11
Housing provider	0	0	1	0	0	1	0	3	0	5
DWP	0	0	0	0	0	0	0	0	0	0
Voluntary organisation	0	0	1	0	1	0	1	0	0	3
Other	1	0	11	0	22	11	6	4	4	59
Not specified	44	32	110	15	82	84	42	42	43	494

Time period in scope by region

A key decision taken early in the SAR process concerns how far back in time the search for information will look. A quarter of SARs (26 per cent) went back further than two years in the individual's life, with 19 per cent seeking information for between one and two years, and nine per cent restricting their search to less than six months. This information was omitted, however, in 29 per cent of the reports.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
0-6 months	5	3	12	6	9	12	3	6	2	58 (9%)
6-12 months	7	7	27	1	23	19	10	11	6	111 (17%)
12-24 months	6	4	21	4	23	32	14	10	13	127 (19%)
24+ months	17	9	38	2	18	36	12	11	24	167 (26%)
Unspecified	12	11	46	4	35	31	22	16	12	189 (29%)

Length of time taken to complete the review by region

The statutory guidance requires reviews to be completed within six months unless there are good reasons otherwise. This was a challenging target to meet even before the COVID-19 pandemic required Safeguarding Adults Boards and their partners to adjust to new ways of working within an unfamiliar environment. Of the 652 SARs included in the analysis, 59 per cent did not specify the length of time taken to complete the review – this is a much larger proportion than in the first analysis, where 32 per cent did not specify the timeframe. Of the 265 reviews in which the time taken was specified, 12 per cent were completed in six months or less (as opposed to 14 per cent in the first analysis); 35 per cent took six to 12 months and 53 per cent took over 12 months (although there were some regional variations in the proportion of SARs completed within these timescales).

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
0-6 months	3	0	9	2	9	5	3	1	1	33
6-12 months	0	1	20	4	23	18	3	8	15	92
12+ months	11	6	31	2	14	39	12	10	15	140
Unspecified	33	27	84	9	62	68	43	35	26	387

SAR panel

Another early decision for SABs is whether to manage the SAR process through the appointment of a panel of senior representatives from the agencies and services involved, commonly referred to as a SAR panel. The table below shows that overall, such a panel is used in about half of all SARs, although there are some regional variations in practice.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
SAR panel convened	21	20	62	6	85	65	22	23	28	332
Percentage of SARs	45%	59%	43%	35%	79%	50%	36%	43%	49%	51%

Identity of SAR authors

The Care Act 2014 statutory guidance encourages, but does not require, a SAR lead reviewer to be independent in the sense of having no prior connection with the agencies or services involved.

In the first national analysis most SAR authors were independent. This remains the case as the data in the following

table show, with 75 per cent of SARs involving an independent reviewer. The percentages in the final column indicate the proportion of SARs in which a reviewer in the given category was involved.

In some cases, more than one reviewer was commissioned, therefore the total of reviewers exceeds the total number of SARs. The 'other' category includes SAB chairs or sub-group chairs, SAB business managers or officers, task and finish groups and staff of partner agencies. In 16 per cent of SARs, however, authorship was not specified. Whilst this is understandable when seven-minute briefings were the only documentation available for this analysis, there were examples too from amongst the full reports and executive summaries in the sample.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Independent	31	28	107	16	73	100	45	41	47	488 (75%)
In-agency	1	1	8	0	9	8	3	1	0	31 (5%)
Another agency	0	0	1	0	1	1	0	0	0	3 <1%)
Other	3	2	18	0	18	8	3	6	7	65 (10%)
Not stated	13	3	21	1	20	21	10	10	7	106 (16%)

The adult's involvement in the review by region

Few individuals were involved in their reviews. In most cases (86 per cent of cases in which involvement information was given), non-involvement was due to the individual being deceased. In the few cases where the individual survived and was involved, this was typically through a conversation with the reviewer. In some cases, the individual had been invited but had declined or not responded. Where they were not invited, reasons were sometimes but not consistently given for the decision to depart from the requirements within the Care Act 2014 statutory guidance. Reasons given included the individual being too ill, that the process would be too distressing, that a criminal process was ongoing or that COVID restrictions prevented contact. Advocacy was rarely used, although one report detailed how an advocate had been commissioned to represent the individual's voice during the process. Equally of concern, mindful of the core principle of making safeguarding personal, is the number of reviews where details of the individual's involvement, or

consideration of it, is not specified. Overall, this appears as a missed opportunity to learn from people with lived experience of abuse/neglect, and of adult safeguarding.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Not applicable (deceased)	39	28	132	16	90	111	50	47	48	561
Not invited	2	1	5	0	6	3	2	1	1	21
Invited but did not participate	1	1	1	0	5	3	1	0	0	12
Consultation on terms of reference	0	0	0	0	0	0	0	1	0	1
Member of panel/review group	0	0	0	0	0	0	0	0	0	0
Conversation(s) with reviewer(s)	1	3	3	0	4	6	1	4	2	24
Reviewed report	0	0	1	0	1	2	0	0	1	5
Contributed written content	0	0	1	0	0	0	0	0	0	1
Supported by advocate	0	1	1	0	0	0	0	0	1	3
Other	2	5	13	1	18	6	4	5	4	58

Family involvement in the review by region

The Care Act 2014 statutory guidance similarly requires that wherever possible family members are involved in reviews. Compared to the first national analysis, the percentage of reviews where family members were not invited to participate has remained constant at eight per cent. Where reasons for not inviting family were given, these included the desktop-only nature of the review, inability to identify next of kin or friends, contact details being unavailable, the individual having been estranged from their family or abused by them, the individual being alive and not consenting, the belief that it would be too painful for the family, that the passage of time made it inappropriate, they were too unwell or involved in ongoing criminal or other processes or that they lived outside the UK. One report indicates that the timescales set out by the approach being taken (a Review in Rapid Time) did not allow sufficient time to involve the family. Another states (erroneously) that as the review was a discretionary SAR, the requirement to involve family

did not apply and argued that family views were in any case already well known. A few reports stated the SAB's intention, having not involved the family earlier in the process, to share the report with them and seek their views before publication.

Where families were involved, once again the most prevalent form of family involvement has been a process of sharing information with reviewers through conversations – 49 per cent in this second national analysis, a rise from 43 per cent in the first national analysis. Relatives sometimes also made written contributions to the report and in one case a family member wrote their own report and presented it at a practitioner learning event. In another example, the reviewer facilitated a restorative meeting between family members and their relative's care home.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
Not applicable (deceased)	0	0	1	0	1	0	2	1	3	8
Not invited	4	1	11	2	12	7	4	4	8	53
Invited but did not participate	4	3	30	1	19	33	11	13	13	127
Consultation on terms of reference	1	0	3	0	1	3	4	2	3	17
Member of panel/review group	0	0	0	0	0	0	0	0	0	0
Conversation(s) with reviewer(s)	21	23	70	10	54	65	26	25	26	320
Reviewed report	3	3	15	0	17	14	10	6	9	77
Contributed written content	2	0	1	0	2	6	4	2	1	18
Supported by advocate	0	0	0	0	0	2	0	0	0	2
Other	13	6	37	5	39	32	15	13	15	175

Timing of parallel processes

A direct comparison between the first and second national analyses is not possible because the template for recording this data was expanded for the second analysis. The table below indicates the proportion of SARs in which parallel processes were noted in the review report, the most common being a coroner's inquest, referred to in 35 per cent of

reports. Parallel processes could be recorded as completed at the time of the SAR report, on-going or expected to start in the future.

Criminal investigations and coroners' inquests commonly occurred prior to a SAR, with serious incident reviews or other types of review within agencies also quite often already completed before the SAR. This mirrors findings from the first national analysis. These prior processes do impact on the time taken to complete a review, which helps to account for the data above relating to the length of the SAR process. In a small number of cases inquests and/or criminal processes ran concurrently with the SAR.

The 'other' category in the table below includes safeguarding enquiries under s.42 Care Act 2014, mental health homicide reviews, mental health unexpected deaths reviews, internal care provider investigations, fatal fire reviews, Local Government and Social Care Ombudsman enquiries, CQC processes, Prison and Probation Service Ombudsman enquiries, patient safety investigations, a large scale enquiry, NHS England investigations, hospital mortality reviews, homelessness fatality reviews, drug related death reviews and British Transport Police Rail Investigation.

	Awaited	Completed	Ongoing	Total
Coroner's inquest	36	171	21	228 (35%)
Criminal investigation	1	89	17	109 (17%)
Serious incident investigation (NHS)	0	73	1	74 (11%)
Serious further offence review (Probation)	0	1	0	1 (<1%)
Domestic homicide review (DHR)	0	2	4	6 (<1%)
Learning disability mortality review(LeDeR)	4	30	2	36 (6%)
Children's SCR/child practice review	0	6	1	7 (1%)
Independent Office for Police Conduct investigation	1	4	1	6 (<1%)
Other Police investigation	1	14	3	18 (3%)
Other	2	77	6	85 (13%)

Process issues in SARs by region

As shown in the table below, one third of the review reports commented on issues that had arisen during the review process itself.

	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire and Humber	All regions
SARs identifying process issues	11	5	56	6	36	39	23	14	23	213
Percentage of SARs	23%	15%	39%	35%	33%	30%	38%	26%	40%	33%

Some of these observations were on positive aspects of the SAR process. They included comments on excellent attendance at learning events held during the review process, with reviewers commending participants' openness, honesty, professionalism, dedication, reflection and commitment to learning. More generally, the co-operation, candour and transparency that agencies showed in providing information drew positive comment, along with their ongoing dedication to the process even in the context of the COVID-19 pandemic pressures. Other features that drew positive comment were the time, commitment and expertise of SAR panel members, SABs' cooperation across geographical boundaries in completing the SAR, rapid action by a SAR chair to escalate matters of concern that required immediate action, and the professional support to the SAR process provided by SAB managers and business teams.

More commonly, however, issues that had a negative impact on the SAR process were identified. Notable amongst these was the COVID-19 pandemic, which started in early 2020. Pressures arising from this had caused delays across multiple SARs, with agencies needing to re-deploy staff to respond to critical service requirements, leaving the SAR very much at the mercy of operational demands. In some cases, the SAR process had been paused completely; in others, the approach taken had been adapted to reduce demands on agencies. This could include prolonged timescales for submission of information, or omission of certain review features such as practitioner learning events, meetings to support agency staff responsible for submitting reports, or meetings with the individual and/or family. For a long period of time all meetings were held virtually, with some delay in setting up the infrastructure for this and initial

technical glitches, although the online environment subsequently became more manageable and in some cases was noted to facilitate participation.

Beyond COVID-19, delays were noted as having arisen for a variety of other reasons: the SAR, or aspects of it, being placed on hold during parallel processes, changes in SAB personnel, SAB staffing demands (and in one case the dissolution of a SAB), long waiting time for toxicology results, addition of a second set of circumstances, or a lack of available independent SAR reviewers. In several cases an original decision not to conduct a SAR had later been overturned due to fresh information coming to light, pressure from a family, or the later commissioning of a thematic review into which the case fitted. More exceptionally, delays were caused by the imposition of a s.114 notice on a local authority and by a legal review of SAB GDPR compliance. While all of these factors are understandable, delay inevitably impacts on family members and some reviews comment on how families experience the length of time taken as disrespectful to their loss.

Other comments on SAR process relate to agency involvement, with a number of reports noting that participating agencies showed poor engagement or commitment to the process, citing failures to respond to communications, failure to supply requested information, submission of poor quality information and non-attendances at meetings. In some cases, agency records were missing, or did not contain sufficient detail to provide answers to questions raised in the review, or reviewers found that the information supplied was inconsistent or inaccurate.

Beyond this, interdependencies with parallel processes drew comment. Delay was foremost here, with SABs commonly waiting for lengthy processes such as inquests or criminal proceedings to be completed before commencing the SAR, or possibly conducting the SAR in two stages – one before the parallel process and one after, when more reflective and evaluative input could be requested. There were some positives to this – inquest transcripts or recordings could add to the information available to the SAR, an inquest could trigger new terms of reference due to new information, and the SAB's participation in the inquest as an interested party enabled the review to access additional information. SARs taking place after other review processes, such as serious incident reviews in health, domestic homicide reviews or LeDeR enquiries, were able to draw on the findings of those reviews while extending the learning more explicitly into health and social care territory.

Conclusion

This report has brought together the findings from stage 1 of this second national analysis of SARs, involving the extraction of data from 652 review reports. It has provided a detailed overview of predominantly quantitative data relating to the characteristics of the individuals whose circumstances are featured in the SARs, the types of abuse and neglect they experienced, and the ways in which the reviews themselves were conducted. The analysis has provided both the overall national picture and a detailed regional breakdown.

The findings should be placed alongside the outcomes of the stage 2 analysis, which involves in-depth thematic analysis of the learning emerging from a stratified sample of 229 reviews. This part of the analysis is contained in a separate report.

The conclusions and priorities for sector-led improvement priorities are set out in a third, separate report.

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