Safeguarding Adult Review (SAR) Policy

1. Commissioning Safeguarding Adult Reviews (SARs)

Dudley Safeguarding Adult Board will promote, develop and embrace a culture which adheres to the requirements and expectations of the Care Act 2014, reflection, learning and transparency when conducting a SAR. The Board will ensure effective systems have been developed and maintained to share the learning within Dudley from SARs. Best practice will be established through a lens of education acquiring knowledge from local/regional and national levels along with any relevant legislation.

In specific circumstances, Dudley Council will conduct a Safeguarding Adult Review (SAR). This process places a duty on all Board members to contribute in undertaking the review, share information and apply the lessons learnt.

Legislation requires Local SABs to arrange a safeguarding adult review when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected and,
- there is concern that partner agencies could have worked more effectively to protect the person at risk.
- The SAB must also arrange a safeguarding adult review when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition, the Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example.

Dudley SAB will lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in “Making Safeguarding Personal”. As such Dudley SAB will identify a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area:
    - the safety of people who use services in local health settings, including mental health
    - the safety of adults with care and support needs living in social housing
    - effective interventions with adults who self-neglect, for whatever reason

2. Raising a SAR

Dudley Council Safeguarding Adults Board has a protocol based on national guidance, which sets out the criteria for holding a Safeguarding Adult Review. The SAR Panel considers referrals for Safeguarding Adult Reviews and makes recommendations to the Independent Chair of the full Board on whether a Safeguarding Adult Review should be held or if other steps can be taken to respond to the issues that a case has raised. Anyone can make a referral to the SAR Panel by contacting the Safeguarding Adults Board manager. Please see appendix B: Contacts

3. How is a Safeguarding Adult Review carried out?

The Panel draft terms of reference for the Safeguarding Adult Review. Each agency involved in the case, including any independent providers involved, arranges for an Individual Management Review (IMR) to be carried out by a manager independent of the case. The IMR reviews the agencies involvement and actions in the case. It has to address relevant aspects of the terms of reference and be based on a set format including a chronology, a review of recorded information and interviews with the key people involved.

An IMR writer can be a suitably skilled and experienced manager from the agency or an independent person commissioned by the individual agency. The completed IMRs are given to the panel and to an independent Overview Report Writer who uses them and any further inquiries they decide to make, to produce an overview report and a draft summary report, including recommendations on actions or changes needed.

The overview report and draft summary report is presented to the Safeguarding Adult Review Panel. The panel reviews the report and recommended actions. These are then presented to the Safeguarding Adults Board for the senior representatives from each agency on the board to consider and agree the proposed actions needed. It then monitors the implementation of these actions with the help of the Safeguarding Adult review Panel. The summary report is published and made available to the public.

4. Safeguarding Adult Review reports

Dudley is committed to learning and sharing its findings from the Safeguarding Adult Reviews as widely as possible in order to enhance learning and inform practice.

5. Roles and responsibilities

Dudley SAB will ensure judgements about events and practice adhere to the following principle. The policy and procedures are based on the six principles of safeguarding that underpin all adult safeguarding work.

In order to meet their core duties and overarching objective, SABs will require information including general and personal data. Personal data is needed to undertake, for example, Safeguarding Adult Reviews and general data is needed to identify trends and patterns in safeguarding activity, abuse and neglect. The grounds on which SABs can require information to be supplied to them are specified in Section 45 of the Care Act 2014

6. Outside of SAR remit

Where the SAB agrees that a situation does not meet the criteria but agencies will benefit from a review of actions other methodologies can be considered. These include:

- Serious Incident Review: Organisations should use their own SI procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations
- Individual Management Review (IMR): IMR's are reviews undertaken by a single agency / organisation and are a critical analysis of that organisation's management of the case. IMR will identify lessons the organisation has learnt from the review and the actions
- Reflective Practice Session: The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead or other such suitable person

The SAB should be primarily concerned with weighing up what type of review process will promote the most effective learning and improvement action to prevent future deaths or serious harm occurring again. 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.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

SARs should reflect the 6 safeguarding principles. SABs should agree terms of reference for any SAR they arrange and these should be published and openly available. When undertaking SARs the records should either be anonymised through redaction or consent should be sought.

The following principles should be applied by SABs and their partner organisations to all reviews:

There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice

The approach taken to reviews 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 and of the organisations whose actions are being reviewed

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

The Local Authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a SAR. Where the adult is deceased, it is good practice to provide advocacy to family/friends.

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

7. Links with other reviews

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR).

Where such reviews may be relevant to SARs (e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs can be effectively managed in parallel so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can be commissioned jointly can reduce duplication of work for the organisations involved.

In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SCR or DHR, a criminal investigation or an inquest.

It may be helpful when running a SAR and DHR or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff.

Any SAR will need to take account of a coroner‘s inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

8. Findings from SARs

The SAB should include the findings from any SAR in its annual report and what actions it has taken, or intends to take in relation to those findings.

SAR reports should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- Be written in plain English
- Contain findings of practical value to organisations and professionals

Completed SAR reports will be published on the local authority’s website with the agreement of the multi-agency partnership. In addition, partners may also choose to publish the report on their own organisation’s website.

Please refer to the SAR flowchart for timescales.