Safeguarding Adult Review Policy

This policy will:

- Assist people to decide when to refer a case for consideration of a Safeguarding Adult Review.
- Provide guidance on the review process.

Abbreviations for key terms used in the policy:

- Hampshire Safeguarding Adults Board – HSAB
- Safeguarding Adults Review – SAR
- Learning and Review Subgroup - LRS

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1.0 Introduction and statutory Criteria

The Care Act 2014 created a legal framework for Adult Safeguarding.
Section 44 of the Act requires local safeguarding adult boards (SAB) to arrange a mandatory safeguarding adult review (SAR) when a case involves an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs) if—

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**

(b) Condition 1 or 2 is met.

(1) Condition 1 is met if:

(a) The adult has died, **and**

(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether it knew about or suspected the abuse or neglect before the adult died).

(2) Condition 2 is met if:

(a) The adult is still alive, **and**

(b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

The Care Act 2014 enables SABs to carry out discretionary SARs or other learning activity in cases which do not meet the mandatory criteria but where it would be appropriate to promote effective learning and improvement action across safeguarding systems to prevent future deaths or serious harm.

The HSAB has developed a SAR Toolkit which offers a range of reviews and audit processes that are used to capture learning from other cases using resources proportionately. The HSAB Methodologies Menu will be referred to by the Learning and Review Subgroup to support appropriate decision making.

The review process is underpinned by the six safeguarding principles outlined in the Care Act 2014. These are the basis upon which judgements are made about events and practice.

Principle	What this means in practice
Empowerment	Presumption of person led decisions and informed consent

Prevention	It is better to act before harm occurs
Proportionality	Proportionate and least intrusive responses appropriate to risks
Protection	Support and representation for those at risk of or experiencing abuse or harm
Partnership	Local solutions through services working with each other and with their communities
A*accountability*	Accountability and transparency in delivering safeguarding practice and support

2.0 Hampshire Safeguarding Adults Board Responsibilities

The Board is responsible for ensuring that effective systems are in place for the completion of safeguarding adult reviews. This includes decision making in respect of commissioning reviews, developing the action plan and agreeing sign off of the report for publication. The National SAR Quality Markers are used as prompts to support good practice.

Responsibility for the management of safeguarding adult reviews is delegated to the Board's Learning and Review Subgroup (LRS). This is a multi-agency partnership from key agencies in Hampshire who work with adults at risk. This group is responsible for maintaining a co-ordination role throughout the process, including providing quality assurance.

The LRS will agree terms of reference, and these will be included in the published SAR.

The SAR will be completed by a reviewer who is independent of the case under review and of the organisations whose actions are being reviewed. This can include reviewers from other partners of the board not operationally involved in the case.

The core skills and experience expected of reviewers are as follows:

- Strong leadership and ability to motivate others
- Promotion of an open, reflective learning culture
- Facilitation skills
- Good analytic skills and experience of collaborative problem solving
- Ability to manage potentially sensitive and complex group dynamics
- Excellent interpersonal skills

- Safeguarding experience and understanding of vulnerability and its impact

When undertaking the safeguarding adult review, the records will either be anonymised using pseudonyms. Involved organisations will be provided with copies of reports for comments on *factual accuracy* prior to final draft. It will be the role of the LRS to ensure the report is factually accurate and based on the evidence gathered during the process.

Once the decision to commission a review has been made, the aim is to complete the process within 6 months, unless otherwise agreed by the Board Chair. It is acknowledged that where a safeguarding adult review is more complex it may require more time. Any urgent issues emerging from a review needing to be considered earlier will be brought to the attention of the board chair.

3.0 The purpose of a safeguarding adult review

The purpose of conducting a safeguarding adult review is to draw out the learning from the circumstances of the case, about the way in which professionals and agencies work together to safeguard the adult at risk. This includes:

- Understanding what happened within a specific period of time
- Understanding why it happened
- Reviewing the effectiveness of multi-agency safeguarding arrangements and procedures
- Informing and improving future practice and partnership working
- Highlighting any good practice identified

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. Such as CQC, the Nursing and Midwifery Council, the Health and Care Professions Council, Social Work England and the General Medical Council. There is also a 4LSAB Multiagency guidance on managing allegations against people in a position of trust where appropriate.

4.0 Making a referral for a safeguarding adult review

Following a serious incident, consideration should be made as to whether a referral for a safeguarding adult review is necessary. To support this, organisations should

consider including an appropriate trigger question on internal incident reporting, investigation and/or review templates.

It is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned, this should take place without delay and in line with the organisation's internal policy requirements. This policy is not intended to duplicate or replace internal review policies and any opportunities to prevent duplication will be encouraged.

Key questions to consider include:

- Was the incident reported internally?
- Has an internal investigation been carried out?
- Has the investigation highlighted concerns about any other organisations?
- Has information become known indicating abuse or neglect as a contributory factor?

The following considerations should be made when deciding whether to make a referral for a safeguarding adult review:

- The concerns must relate to a person with needs of care and support – whether in receipt of services.
- Abuse and/or neglect is known or strongly suspected to have contributed to the harm caused.
- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

If the SAB requests relevant information from a body or person in the context of a safeguarding adult review, 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.

Should a body or person fail to comply with Sec 45 the request will be escalated via the Board Chair and the appropriate senior representative within that body. If the request is not supported at this stage, legal advice will be sought, and recommended actions followed.

The person and/or their representative should be informed of the concerns and that a safeguarding adult review referral is planned, providing an opportunity for them to give their view about the referral. However, a referral does not require consent from the person and/or their representative.

To make a referral, the referral form should be completed and submitted to the HSAB. The referral form can be found within the SAR Toolkit.

5.0 Decision-making

The LRS will consider each referral. Each referral has an initial triage process with the three statutory partners represented. If a referral progresses the involved agencies will be contacted by HSAB to request completion of a scoping chronology to inform decision making. If a referral does not progress, it will still be heard at the next LRS to ensure robust decision making.

The LRS has representatives of the three statutory agencies (Local Authority, Police and Integrated Care Board), who have a particular responsibility to agree on the recommendation to commission a Safeguarding Adult Review. They are supported in their decision making by representatives of other key local agencies who form the LRS. The Chair of the board is ultimately responsible for deciding whether to commission a safeguarding adult review, advised by the recommendation of the LRS.

The Chair of the Board will delegate the responsibility of commissioning a SAR to the HSAB. This includes consideration of the most appropriate methodology to use which will be confirmed between the LRS and the independent SAR author.

The Chair of the LRS will inform the referrer in writing of the decision and notify the Care Quality Commission (regulator of health and social care services) if regulated services are involved.

For cases not meeting SAR criteria, the LRS may consider arranging another type of review as outlined in the SAR Toolkit.

6.0 Methodology

The process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. 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 SAR methodology chosen should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted. All agencies involved in the case should be fully engaged in the SAR process and have the opportunity to contribute their views.

Should there be concerns about an agency's non-engagement with a SAR, this will be escalated in the first instance to the Chair of the LRS, and ultimately to the HSAB Chair. 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.

7.0 Responsibilities of the Safeguarding Adult Review Panel

For each SAR a decision will be made whether the LRS can fulfil the responsibilities of a safeguarding adult review panel, or whether a separate panel is required.

The role of the Review Panel is to agree the terms of reference, review the progress of enquiries, consider all data being submitted before the Panel, give consideration to the findings and conclusions and make recommendations in relation to what action is required to address the learning identified.

It is expected that all Review Panel members will attend each Panel meeting. Each Review Panel member has a key role and professional responsibility within the SAR process. Agencies must be robust in selecting their nominated panel member and be clear on time commitment for the panel meetings and involvement in the review including preparation between and for panel meetings. It is imperative to the integrity of the safeguarding adult review process to ensure it is quorate at each meeting of the Review Panel meetings and that there is continuity.

Once the Review Panel is established, nomination of any deputy panel member is only permitted under exceptional circumstances. It is a requirement for the panel members to prepare for each panel meeting thoroughly and input in other ways that the Review Panel Chair or Overview Report Author may require.

The Review Panel will be quorate when the police, health and local authority representatives are present.

8.0 Interface with other proceedings or investigations

Some safeguarding adult reviews may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a safeguarding children practice review. The chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

There may be criminal or coronial investigations running concurrently with the SAR. Any proposals for a SAR must ensure that they do not prejudice criminal or judicial proceedings. In cases where criminal proceedings are taking place the LRS Chair should discuss how the review process should take account of these with the relevant criminal justice agencies (such as the police and the CPS) before planning the SAR.

Consideration should be given to, for example, effects on timing, the way in which the review is conducted (including any interviews of relevant personnel), what the potential impact on criminal investigations is and who should contribute at what stage. Work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings. It is essential the SAR reviewer liaises closely with the relevant senior investigating officer from the other agencies concerned to make sure that professionals and members of the public that are likely to be called at a witness trial are not compromised by the activity of the review. It may also be necessary to delay the publishing of reports until the conclusion of any criminal trial. However, individual agencies can progress with implementing the learning from the review.

9.0 Independent advocacy

Under Section 68 of the Care Act 2014, an independent advocate must be arranged (where necessary) to support and represent an adult who is the subject of a SAR if it is judged they would experience substantial difficulty in participating in the review process. This includes a person assessed as having capacity to make decisions about their care and support, where there is no other suitable person to support them. Where an independent advocate has already been arranged under s67 Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate should be used. It will be the responsibility of the HSAB to arrange and fund advocacy support in these circumstances.

Often the SAR process involves family members as representatives for the adult and if required advocacy can be arranged to support the family member. Where an adult has died and there is no known family representative the decision to engage advocacy will be on a case-by-case basis. The LRS will endeavour to ensure the adults voice is present in the review.

10.0 Responsibilities to the person and their representative(s)

The person or their family/representative are made aware that the review is taking place and offered the opportunity to contribute to the review process. They should be kept updated at key stages of the review and notified of the publication of the report.

The LRS Chair and the Independent Reviewer will agree who is best placed to contact the person or their family/representative. However, consent is not required for the review to go ahead.

11.0 Responsibilities to staff

The staff directly involved in the care and support of individuals subject to a safeguarding adult review should be notified by the agency they are employed by, of the decision to undertake the review and support should be provided to them, including being signposted to this policy.

At the end of the process HSAB should consider whether staff should be invited to a feedback session, co-ordinated by the LRS representative of the agency concerned in conjunction with the HSAB.

12.0 Reporting arrangements

The LRS will provide regular updates to Hampshire Safeguarding Adults Board on the progress of the review. The recommendations or questions for the board to consider are to be developed by the LRS or the safeguarding adults review panel with the independent reviewer. Once completed, the report and recommendations or questions for the board to consider will be presented to the Hampshire Safeguarding Adults Board for consideration.

Once the report is approved, the LRS will produce a multi-agency action plan responding to any recommendations made. Monitoring of the implementation of this action plan will be undertaken by the HSAB SAR coordinator. The norm will be to publish an anonymised version of the full report on the HSAB website and the national Safeguarding Adult Review Library However, in exceptional circumstances and only with the agreement of the Board, this practice may vary.

As a means of signing off the SAR and its resulting action plan, the LRS will complete an evaluation detailing the outcomes as result of the actions undertaken from the review. Collated findings from the review will be included in the HSAB Annual Report.

13.0 Media, communication and publication

Media and communication will be co-ordinated by the Hampshire County Council Communications Team on behalf of the Board. The board team will lead a

coordinated approach in publication planning of all SAR material with the agencies involved.

Safeguarding adult reviews will be published on the HSAB Website unless a decision is taken not to publish for any reason. At the point of publication, the Board Chair will release a statement outlining the reasons for the review and key findings.