SAFEGUARDING ADULTS REVIEW (SAR)

Decision Support Guidance

Version Control
2.3

Teeswide Safeguarding Adults Board

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Revision Number	Date Approved by the Board	Change Record	Links to Other Policies	Review Date:
2.1	Mar-20	Domestic Abuse added to types of abuse	Safeguarding Adults Review Policy and Procedures TSAB inter-agency Policy and Procedures.	Apr-20
2.2	Sep-20	Flowchart amended, Types of reviews and methodology added.	Safeguarding Adults Review Policy and Procedures TSAB inter-agency Policy and Procedures.	Sep-21
2.3		Flowchart reviewed and amended.	Safeguarding Adults Review Policy and Procedures TSAB inter-agency Policy and Procedures.	Apr-22
2.3	Jan-24/ SAR Sub-Group	No Changes	Safeguarding Adults Review Policy and Procedures TSAB inter-agency Policy and Procedures.	Jan-26

1. Introduction

There is a need to apply and demonstrate a consistent approach to decision making in relation to Safeguarding Adults Reviews notifications (SAR01). This decision support guidance has been developed specifically to be used by the SAR Sub-Group when considering SAR notifications.

2. The Care Act 2014

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

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

3. Using this guidance

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

4. Criteria for Safeguarding Adults Review

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

1. dies either as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult;

Or

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

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

5. Serious Types of Abuse

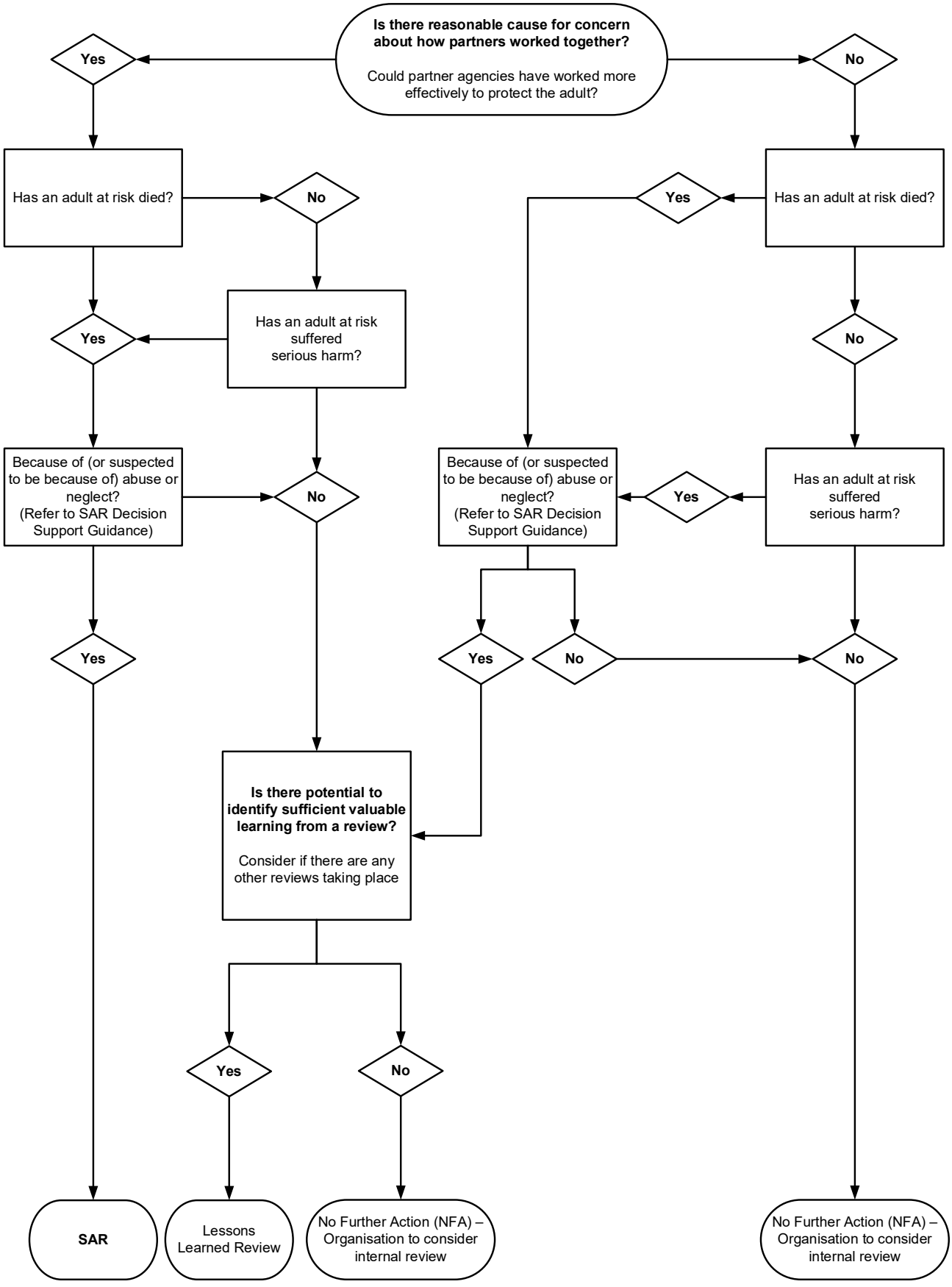
The following table indicates the types of abuse that are considered to be serious in nature and relevant to decision making in relation to SARs.

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

6. Multi-Agency Working

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

7. Safeguarding Adult Review (SAR) - Decision Making Process



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

8. Types of Review and Methodologies

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

a. The approach taken to review a case should be proportionate according to the scale and level of complexity of the issues being examined
b. Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
c. Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
d. Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively
e. The Board should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons, for example because of potential prejudice to related court proceedings.

Some examples of methodologies are provided below.

Traditional Serious Case Review Model

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

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

Learning Together Review

This is a systems-based approach to reviewing a case. Learning Together reviews are conducted by a multi-agency 'Review Team' which is led by two Lead Reviewers (accredited by the Social Care Institute of Excellence (SCIE)). This approach provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to be mistaken or to have led to an unwanted decision, seemed to those involved, to be the sensible thing to do at the time.

Once the two Lead Reviewers have been commissioned, they will bring together the Review Team for an Introductory and Scoping Session. The Review Team will be managers/senior managers representing the agencies involved in the case and SAR Sub-Group members. The Review Team plays a key role in the review, including talking to staff, reviewing documentation and analysing data, identifying any priorities revealed by the case. Review Team members should not have had any decision making role in the case being reviewed.

This introductory session will be followed by an Initial Planning meeting between the two Lead Reviewers and the Review Team. This will include identifying staff who were involved in the case and these will form the Case Group. An Introductory meeting for the Case Group will be facilitated by Lead Reviewers with involvement from the Review Team. This is followed by Individual conversations where the Review Team will meet with staff involved in the case. The key principle within this process is 'no hindsight bias' and supports practitioners to learn from their practice. Once

these individual conversations have taken place a first analysis meeting will be held with the Review Team to agree Key Practice Episodes (KPEs) in the case**.** The Lead Reviewers will then start writing the report.

A Second analysis meeting with Review Team will be held to review and discuss data/documentation and check draft report. Further analysis and follow-on meetings will be held to share the generalised learning with the Case Group and get their input about the underlying patterns that have been identified. The report will be finalised after the fourth analysis meeting.

Appreciative Inquiry

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

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

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

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

1. Introduce themselves and their best strengths in challenging times.
2. Inquire into one another's work with the individual, asking about:
    a. those interventions that were successful in keeping them safe
    b. those things that with the benefit of hindsight should have been done differently.
3. Create a multi-agency timeline story by sharing practitioner's answers to the two questions above
4. Reflect together on all the things that worked well, and all the areas that people could now see should have been done differently
5. Seek new ideas about the redesign of those things that must change to enable the whole system to get better at keeping adults safe
6. Make individual and shared commitments to on-going development, action and change.

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

Significant Incident Learning Process (SILP)

SILP explores the professional's view of the case at the time the events took place. It analyses significant events and deals not only with what happened but why it happened. SILP can show what affected the practitioner's actions and decision making at the time and what needs to change.

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

Peer Review

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

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

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

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

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