City of York Safeguarding Adult Board

Procedure

For

Safeguarding Adult Reviews

March 2023

review March 2025

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CITY OF YORK SAFEGUARDING ADULT BOARD

1. Introduction

Section 44 of the Care Act 2014 and subsequent statutory guidance bestows a duty on the Safeguarding Adult Board to undertake a Safeguarding Adult Review where an adult in its area with care and support needs has died or been seriously harmed as a result of abuse or neglect.

The following describes the procedure for undertaking a review.

2. Principles of a Safeguarding Adult Review

The following six principles of safeguarding adults will be applied to a Safeguarding Adult Review (SAR) by the City of York Safeguarding Adult Board (SAB) and its partner organisations:

- **Empowerment** – The adult, their family and friends (where appropriate) will 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.
- **Prevention** – Safeguarding Adult Reviews should seek to determine what each relevant agency and individual involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be identified and those lessons applied to future cases to prevent similar harm occurring again.
- **Proportionality** - The approach taken to a SAR will be proportionate according to the scale and level of complexity of the issues being examined.
- **Protection** - There is a culture of continuous learning and improvement across partners in all 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. Partners will not wait

until after a review is completed to implement any lessons identified to protect individuals.

- **Partnership** – Professionals will be involved fully in Reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

- **Accountability** - Reviews will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. There should be evidence that those who are appointed to lead the review are sufficiently skilled and experienced in adult safeguarding matters. The findings from a Review and what actions have been taken or are intended to be taken will be reported by the SAB in its annual report. Progress will be monitored by the Board until actions are completed.

3. Purpose of a Safeguarding Adult Review

The purpose of having a Safeguarding Adults Review is to seek to determine what each organisation involved in the case might have done differently both individually and collectively that could have prevented harm or death.

The objectives include:

- ❖ preparing or commissioning an overview which brings together and analyses the findings of the various agencies in order to make recommendations for future action
- ❖ establishing whether there are lessons to be learnt from the circumstances of the case about the way in which:
  - o local professionals and agencies work together to safeguard adults with needs of care and support
  - o regional professionals and agencies work together to safeguard adults with needs of care and support where cases cross more than one local authority boundary
- ❖ reviewing the effectiveness of both multi-agency and individual agency policies and procedures
- ❖ informing and improving local inter-agency practice

- ❖ improving practice by acting on learning and developing best practice

The purpose of having a Safeguarding Adults Review is not to investigate and apportion blame to an individual or an organisation. It is also 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 the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council. If there are issues of performance and/or discipline which need to be addressed arising from the review, then these must be dealt with within each agency's normal procedures.

4. Criteria for conducting a Safeguarding Adult Review

Section 44 (1) to (3) places a DUTY on the SAB to arrange for a review where the following criteria are met:

1. *The case involves an adult in its area;*
2. *The adult has needs for care and support (whether or not the local authority has been meeting any of those needs);and*
3. *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.*

In addition, one of the following conditions must apply:

1. *the adult has died and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died);or*
2. *the adult is still alive and the SAB knows or suspects that the adult has experienced "serious abuse or neglect".*

There is no definition in the Act of serious abuse or neglect. However, the statutory guidance (March 2016) advises that:

....something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an

intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. (paragraph 14.163)

In addition to the duty to arrange Safeguarding Adult Reviews, section 44(4) Care Act 2014 provides that SABs may carry out a SAR in any other case involving an adult with care and support needs where they feel it would be appropriate.

5. Referral of cases for consideration of a Safeguarding Adult Review

Any agency or professional may refer a case believed to meet the criteria.

Referral can be made to the chair of the Review and Learning Group directly or to the City of York Council (CYC) Adult Safeguarding Service Manager together with:

- a brief summary of the case identifying the factors that suggest the criteria for a SAR may be met (Appendix A)
- where possible and practicable the views and wishes of the adult (where still alive) and/or their family members.

Enquiry leads will be particularly well placed to identify cases that may fit the criteria and warrant review.

In addition to the above on a monthly basis safeguarding leads from the three statutory SAB partners will hold a Section 44 meeting to look at cases reported to the safeguarding team which require multi-agency scrutiny at a senior level.

The attendees will gather and analyse case information in preparation if required for the case to be considered by Review and Learning sub-group.

Some cases will be screened out of further review at this stage. The cases for this meeting will be identified by the respective safeguarding leads.

6. Review and Learning Group

The Review and Learning Group (RLG) is a subgroup of the SAB.

The RLG will consider any referrals received and decide if, from the information provided, the case meets the criteria outlined in section 44 or where further information is needed, request additional information be provided to the group within a given timescale.

The RLG will make their recommendation to the SAB chair. The decision whether or not to conduct a SAR and its scope and management rests with the SAB chair who may choose to consult further with other members of the SAB before making a final decision.

The SAB chair will confirm the decision to the RLG chair and CYC Adult Safeguarding Head of Service.

Where a case may appear to fit the criteria for more than one statutory review; for example - Domestic Homicide Review (DHR), Child Safeguarding Practice Review (CSPR), Mental Health Homicide Independent Investigation (MHII), consultation should be sought at the earliest convenience as to whether the reviews can be conducted jointly or collaboratively.

Where a case does not fit the criteria for a SAR but the RLG and SAB chair still believe there are lessons to be learnt and circumstances indicate that further examination is required, the RLG, with the approval of the SAB chair may take the decision to complete a non-statutory safeguarding adult review.

7. Conducting a Safeguarding Adult Review (SAR)

When the decision to complete a SAR is made the CYC Head of Safeguarding in conjunction with the SAB chair and RLG chair will agree who will take the lead to complete the following actions:

- If required appoint a person independent of the SAB and the organisations involved in the case to formally lead and chair the

SAR panel and request a senior representative from the agencies involved to sit on the SAR panel (this will only be required by exception; the default position being that the RLG will be the panel)

- Appoint an independent author to conduct the review and complete an overview report with an executive summary (if required). The independent author may also be SAR panel chair if one is required.
- Inform the Coroner of the review if the case involves a person who has died
- Where necessary inform the regulating authority of the agencies involved e.g. Care Quality Commission
- Inform the relevant Council Member through contact with the Council Executive Member for Adult Social Care & Health
- Agree a time-frame for completion

The SAR panel / RLG in conjunction with the independent author will complete the following actions:

- agree engagement and maintain on-going communication with the adult and/or family members in the SAR process
- draw up and agree terms of reference for the review which reflect the key issues in the case; making safeguarding personal; and the six safeguarding principles
- agree the methodology for the review which may include the process of each agency completing an individual agency chronology and management review or a suitable alternative methodology (see section 11)
- complete an overview report and executive summary (if agreed) along with any joint recommendations
- agree ‘check and challenge’ panels to review and quality assure report and associated information

SAR Panel / RLG should ensure that the information from all contributing agencies is fully and fairly represented in the overview report.

8. Implementing the Recommendations

The completed SAR report and recommendations will be presented to SAB for final sign off.

The recommendations and implementation of any action plans and learning will be overseen by the RLG and the SAB. The on-going monitoring, reviewing and subsequent audit of learning will be completed by SAB through it's sub-groups.

Each agency is responsible for implementing relevant recommendations contained in their action plans within the timescales agreed.

9. Communications

The SAB will agree to whom the report or parts of the report should be made available. In particular, consideration must be given to publication of reports both internally within agencies and externally on the SAB website. It may be necessary for each agency's media and communications department to agree a joint strategy.

The SAB will agree whether an executive summary or the full report will be published on the City of York Safeguarding Adult Board website in order to support information sharing and the principle of accountability.

The SAB Chair will ensure dissemination of the report in full or in part to other interested parties as agreed and ensure that the subject of the review and/or their family receives feedback.

10. Methodologies

The Care Act 2014 is not prescriptive about the process for completing reviews. The following list are some suggested methodologies, but it is by no means exhaustive and it is acknowledged that the SAB may wish to follow a process not described here, which fulfils the purpose of review. The SAR Quality Markers (SCIE 2022) checklist is identified as a

helpful tool to support people involved in commissioning, conducting and quality assuring SARs to know what good looks like.

i. Standard multi-agency review

Each agency provides a chronology of events of their involvement analysing their information against policies and procedures; identifying best practice and also highlighting any concerns or issues. Further in-depth analysis may be requested in the form an internal management review (IMR) or through specific questions posed to further scrutinise particular key events or issues.

ii. Peer review

Where there is only one agency involved but an independent external review of the circumstances is indicated the SAB chair can request a member of the Board (or a representative from their agency) to undertake a peer review. The format of this review will be agreed by the agency, the external reviewer and the SAB Chair.

iii. Single agency review

The SAB Chair may request a partner agency to undertake their own review where concerns are isolated to that agency. This may take the format of an IMR with an agreed terms of reference or an alternative process e.g. NHS Serious Incident Investigation may have been conducted which is shared with the SAB.

iv. Significant event analysis

This approach brings together managers and/or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.

The process followed in a Significant Event Analysis is as follows:

- Information gathering – collation of as much factual information about the concern as possible

- Facilitated workshop to analyse the information/event – operated fairly, openly and in a non-threatening environment

- Consideration of key questions:

    - How could things have been different?
    - What can be learned from what happened?
    - What has been learned?
    - What has or needs to change or be actioned as a result?

There is an expectation that all of the above reviews will be presented to the SAB by their relevant leads or agencies to give the SAB assurance that there is a culture of continuous learning and improvement across partners in all organisations.

11. Annual Report

All reviews conducted within the year should be referenced within the SAB Annual Report along with any relevant service improvements. The Annual Report will be published on the City of York Safeguarding Adult Board's website.

https://www.safeguardingadultsyork.org.uk/

12. References

Care Act 2014
https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Care Act 2014 Easy Read
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365345/Making_Sure_the_Care_Act_Works_EASY_READ.pdf

Care and Support Statutory Guidance
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

SCIE 2022 Safeguarding Adult Review Quality Markers

https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-quality-markers-comprehensive-checklist.pdf

Appendix A

SAFEGUARDING ADULT REVIEW (SAR) – CASE REFERRAL FORM

Please complete the form with as much information as possible

Name of the adult:

Address:

Date of Birth:

Date of Death (where applicable):

Ethnicity:

Name and address of GP:

Health / social care needs - include any physical or mental health and care and support needs

Brief summary of the case indicating any actions already taken:

Agencies known to be involved:

Identify the factors that suggest this case may meet the criteria for a SAR:

Views of adult and/or views of family members

Name of Referrer:

Agency:

Date of notification to RLG:

Date considered by RLG: (to be completed by subgroup Chair)

Decision/Action taken: (to be completed by RLG Chair)