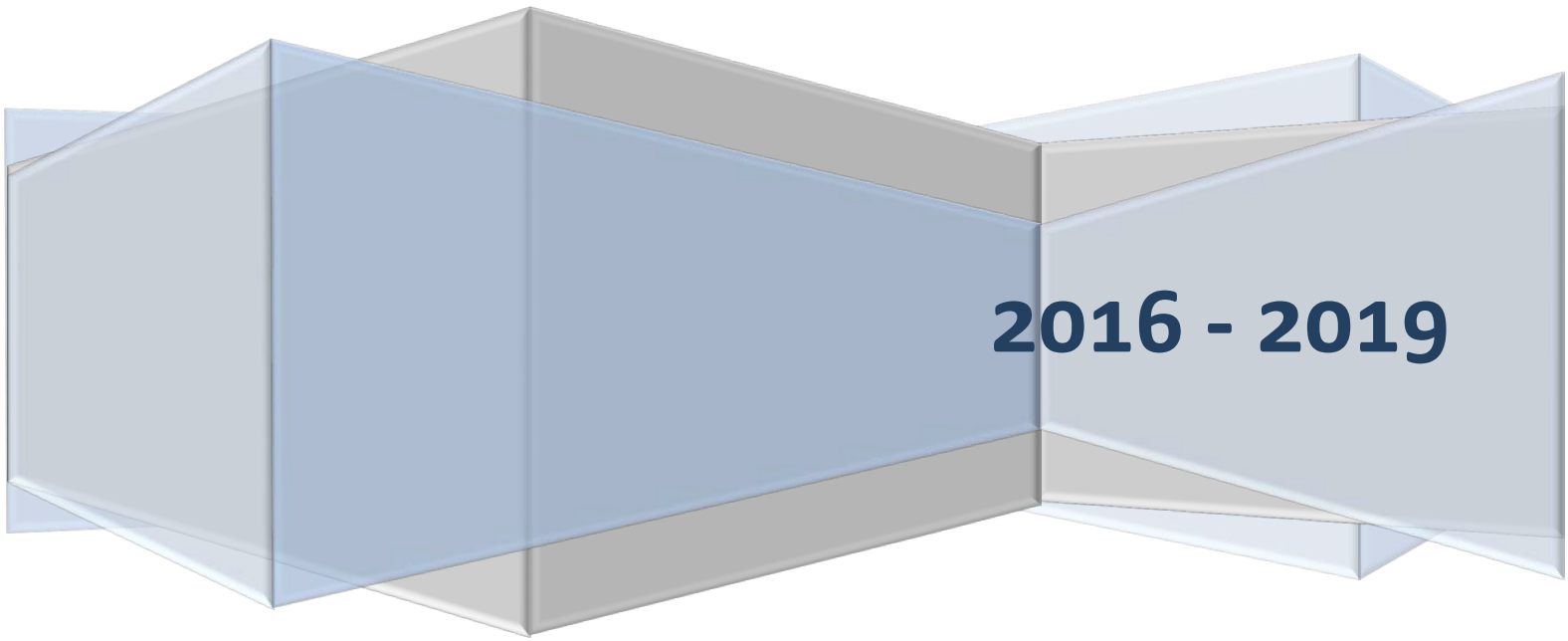
Safeguarding Adults Review

Policy, Procedure and Good Practice Guidance



Contents

ACKNOWLEDGEMENTS

This policy has been developed with reference to the following documents:

Hampshire Safeguarding Adults Board Safeguarding Adult Review Policy May 2015

Dorset Safeguarding Adults Board and Bournemouth & Poole Safeguarding Adults Board Safeguarding Adults Review Policy May 2015

Cheshire West and Chester Local Safeguarding Adults Board Safeguarding Adult's Review Policy and Procedure July 2015

Warrington Safeguarding Adults Board Safeguarding Adult Review Procedure 2015

Care Act 2014 Care and Support Guidance, Department of Health (updated 2016)

GLOSSARY

CQC	Care Quality Commission
DHR	Domestic Homicide Review
HSAB	Halton Safeguarding Adults Board
IMR	Individual Management Review
NHS	National Health Service
RCA	Root Cause Analysis
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SIRI	Serious Incidents Requiring Investigation

POLICY:

1. INTRODUCTION

The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in Section 1 of the Care Act 2014 (implemented April 2015). Safeguarding Adults Boards are a statutory requirement under the Care Act.

Halton Safeguarding Adults Board (HSAB) oversees and leads adult safeguarding across the locality and has a range of statutory duties that contribute to the prevention of abuse and neglect. This includes the duty to conduct any Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act. SARs are reviews that examine the way agencies and individuals have acted when they have been involved with an 'adult at risk'.

There are three broad circumstances under which the Care Act statutory guidance considers a SAR may take place. The guidance makes a distinction between those circumstances where the SAB **must** and **may** arrange a SAR.

The SAB **must** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

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

Either

a) 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

b) The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect

A SAB **may** also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs). 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. In cases where there is learning but the case does not meet the thresholds for a full SAR the Independent Chair may recommend a step down review in the form of an Individual Management Review.

Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to:

a) Identifying the lessons to be learnt from the adult's case, **and**
b) Applying those lessons to future cases

2. PRINCIPLES

The Safeguarding Adult Review processes are underpinned by the following principles:

- 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

3. PURPOSE

The purpose of conducting a Safeguarding Adult Review is, to establish whether there are any lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk. The Safeguarding Adult Review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary. Specifically the purpose of the Safeguarding Adult Review is to:

- Determine what might have been done differently to prevent the harm or death

- Identify lessons and apply these to future cases to prevent similar harm again

- Review the effectiveness of multi-agency safeguarding arrangements and procedures

- Inform and improve future practice and partnership working
- Improve practice by acting on learning (developing best practice)
- Highlight any good practice identified

The purpose of a SAR 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 Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professionals Council and the General Medical Council.

The learning as a result of a Safeguarding Adult Review needs to be shared and the statutory Duty of Candour places a requirement on providers of health and adult social care to be open with people and their families when there are failings or things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

A SAR should highlight any lessons that can be learned from the case through a clear set of recommendations; ensure that relevant actions are taken in order to help prevent future deaths or serious harm. This helps to improve both single and inter-agency working and better safeguard and promote the wellbeing of adults at risk.

PROCEDURE:

4. MAKING A REFERRAL FOR A SAFEGUARDING ADULT REVIEW

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 or not in receipt of services
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused
- There are concerns about systematic failings relating to multiple organisations and so there is potential to identify to improve multi-agency practice and partnership working
- The family should be informed of the concerns and that a Safeguarding Adult Review referral is planned and so providing an opportunity for them to give their views about the referral and to discuss how they might want to be involved

Only Halton Safeguarding Adults Board can commission a Safeguarding Adults Review in the borough of Halton. However, any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR. All agencies should have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning and this policy is not intended to duplicate or replace these.

Where any individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they should refer the case to the Chair of Halton Safeguarding Board to consider if a SAR is required. Prior to making a referral, professionals working with adults at risk should consider the relevant guidance and discuss with their organisation's line manager or SAB representative.

By virtue of the criteria, in cases where a SAR may be initiated, a safeguarding concern and/or enquiry may already have been made. Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to the Inter-Agency Safeguarding Adults Policy, Procedure and Good Practice Guidance, which considers any immediate protection required. However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have committed suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

A referral is made by completing a referral form (***please see Appendix 1***). Referrals should be made as soon as it is apparent to the agency/organisation that they believe the SAR criteria has been met. An unreasonable delay in raising any issue can impact on the process and the key purpose in a number of ways.

The SAB will not review cases that are more than 12 months old, unless there is significant information that has recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. The decision to take on cases that go outside the time limit, would need to be referred to the Chair of HSAB for a final decision.

5. DECISION MAKING

On receipt of a SAR referral form, the Chair of HSAB will consider the information provided on the completed referral form. The Chair may seek further information including clarity about any parallel investigations that may be taking place.

The Chair of the SAB will make the final decision about whether a SAR should take place. On making the decision, the Safeguarding Adult Board Support Officer will write to the referrer and advise them of the outcome. In circumstances where the Chair of HSAB decides not to progress further with a referral at this stage, the reasons for this will be recorded and a response and explanation will be provided to the referrer.

If the Chair of HSAB decides that a SAR should take place, there are two levels of SAR which can be utilised:

Level 1 (Statutory) SAR will be required for those circumstances in which the SAB must arrange a SAR

Level 2 (Discretionary) SAR may be conducted in any other situations

The review methodology to be used will not be pre-determined by the level of SAR utilised, but after consideration of the particular circumstances of each case. In any SAR, the approach should be proportionate to the scale and complexity of the issues and the potential for learning.

In any instance where the Chair of HSAB has decided a SAR should not take place, the reasons must be recorded and shared with the referrer and HSAB. However, it may be decided that there is still learning from the incident in this case, an Individual Management Review may be requested (***please see section 8***). Learning from this review should still be disseminated and shared across HSAB agencies and any other relevant regional or national networks.

6. COMMISSIONING A SAFEGUARDING ADULT REVIEW

The Care Act guidance states that the Board should aim for completion of a review within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required.

On receipt of the SAB Chair's decision to undertake a SAR, the Chair, Director of Adult Social Services and the Safeguarding Adult Board Support Officer, will liaise in order to make the necessary arrangements. This will include:

- Notifying the referring agency, SAB members and other interested parties (including CQC and the Coroner)
- Setting up a Safeguarding Adults Review Panel
- Identifying appropriately qualified and experienced leads (Chair, facilitator, author as required) identifying and securing the necessary support and budgetary requirements
- Notifying the adult and/or their family as appropriate
- Considering an initial scope and timescales
- Initiating any information requests that are required

- Considering media and communication strategies

Once the decision has been communicated, each agency will be responsible for taking appropriate actions that may be necessary in relation to the security of their records. No member agency should comment publicly upon the case without express agreement of both their senior management team and the Chair of HSAB.

7. THE SAFEGUARDING ADULT REVIEW PROCESS

The Safeguarding Adult Review is overseen by the Halton Safeguarding Adults Board which is a multi-agency partnership with senior management representation from all of the key agencies who work with adults at risk in the borough. The Board is responsible for ensuring that effective systems are in place for the effective completion of SARs, for decision making in respect of commissioning reviews, formally accepting reports and agreeing sign off of the report for publication. In most cases a SAR Panel will be required to undertake and oversee the review and report to the SAB on a regular basis. The SAR Panel should be selected on the basis that they had no immediate line management of the case under review, and should normally include representatives of the three SAB statutory agencies (Local Authority; Police; Clinical Commissioning Group). The panel and associated arrangements should be proportionate to the circumstances of the case and the review methodology.

The Safeguarding Adult Review Panel will set their own meeting schedule and timings appropriate to the case and the methodology; and report this to the Board. Whilst the frequency and number of meetings may vary, the SAR Panel will in most instances progress through the following three stage process, in order to establish; monitor and finalise the review:

Stage 1

The Panel will have responsibilities from the outset to:

- Specify the Terms of Reference
- Set timescales, if not already determined
- Confirm the lead roles such as Chair, Facilitator, Author and the planned methodology to be used
- Links to other interested parties such as the Crown Prosecution Service or Coroner
- Coordinate and compile the available information including chronologies and reports of investigations that may have taken place
- Confirm the agencies and the people involved and affected
- Identify, inform and establish links to any other processes ongoing or planned
- Where required, request that Independent Management Reviews are completed
- Identify any additional reports, information or evidence required

- Agree the nature and extent of expert or legal advice required
- Develop media and communications plans and with appropriate advice, publishing considerations
- Consider how the adult, advocate and/or family can be involved in the SAR, including any issues relating to Duty of Candour
- Set future panel meeting dates and times

Stage 2

During this phase the following functions are likely to be required of the Panel (with flexibility according to the methodology used and proportionate to the circumstances).

- Maintain links with interested parties and parallel investigations
- Produce a comprehensive chronology that covers that critical period collated from all agencies
- Receive and scrutinise additional reports including IMRs and safeguarding/serious incident investigations
- Cross reference information within the reports, identify any omissions or discrepancies
- Conduct/commission any further enquiries
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Identify critical points and actions with any key lines of enquiry
- If the methodology requires a workshop or learning event, then this will be planned and delivered
- Develop a framework for the report and consider drafts
- Review progress and timescales and report to the SAB

Stage 3

During this stage, the members of the SAR panel will discuss and agree the key learning points of the review, the recommendations and actions required; and finalise the report. Some of this work may be able to be undertaken outside of meetings, in which case panel members must commit to prioritise input and feedback to reports that are circulated within timescales.

On completion, the SAR report will be presented to the SAB which will:

- Ensure contributing agencies have the opportunity to confirm the accuracy of facts and interpretation of their involvement in the report
- Confirm the recommendations from the report
- Confirm action plans, which should be endorsed at senior level by each organisation and agree accountability

- Confirm to whom the review or parts of the review are to be made available (decisions on publishing will have been taken before completion of the review)
- Commissioning the dissemination of the review of key findings to interested parties including feedback and debriefing to staff, family members and media
- Confirm the arrangements to ensure that the actions are monitored and updates requested from agencies
- Sign off the action plan when complete

In Halton, the SAB will normally exercise its function of oversight of the actions via the Safeguarding Adult Review Panel. The panel should ensure that identified actions are completed and any barriers or slippage in achieving outcomes are responded to.

If the Board requests information from an organisation or individual who is likely to have information which is relevant to SABs functions they **must** share what they know with the Board in accordance with the Care Act 2014.

The Safeguarding Adult Review will be undertaken by people who are independent of the case under review and of the organisation whose actions are being followed. The core skills and experience expected of a reviewer are as follows:

- Appropriate level of seniority
- Strong leadership and ability to motivate others
- Inclined towards promoting an open, reflective learning culture
- Expert facilitation skills
- Experience of more than one review methodology
- Good analytical skills and experience of collaboration 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 SAR, records will be anonymised. Involved organisations will be provided with copies of reports for comments on factual accuracy prior to final draft. Where a SAR Panel is established it will be the role of the panel to ensure the report is factually accurate and based on the evidence gathered during the process.

The SARs must be completed in a timely manner. Once the decision to commission a review has been made, the review should be completed within six months or if otherwise, this would need to be agreed by the Chair of SAB. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Board Chair. It is acknowledged that where a safeguarding adult review relates to serious organisational abuse or where multiple perpetrators are involved, such reviews are likely to be more complex and therefore may require a longer time period to complete.

8. SAFEGUARDING ADULT REVIEW METHODOLOGIES

The process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. The SAB will give consideration to the most appropriate methodology to use as no one model will be appropriate for all cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however, it will be determine by, and be proportionate to, the specific circumstances and the scale of the situation. 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 up and monitored by HSAB.

Methodologies that would usually be considered for the most serious cases include traditional Serious Case Review/Domestic Homicide Review, action learning and peer review approaches. Other methodologies include but are not confined to a multi-agency practice learning review, a root cause analysis, or a significant event analysis. There is flexibility in determining the precise process including variations and combinations of methodology elements on a case by case basis.

Examples of different types of methodologies include:

Traditional Model

This methodology, a traditional model, forms the basis of Domestic Homicide Reviews (DHRs) and Serious Case Reviews (SCRs) in similar fields and historically in adult safeguarding. Typical features include:

- Appointment of a panel, including a Chair (usually independent) and core membership which determines Terms of Reference and oversees process
- Independent report author
- Combined chronology of events
- Involved agencies produce Individual Management Reports, outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the commissioning board and monitoring implementation across partnerships

Individual Management Reviews

Individual Management Reviews (IMRs) are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes or individual and organisational practice could be enhanced. They are key learning tools used in several of the SAR methodologies and other similar reviews such as DHRs and SCRs. They can be used in a multi or single agency environment.

It is important that individuals who are asked to undertake IMRs have the relevant skills and sufficient independence from the case being reviewed.

Where it is decided that IMRs are required:

- The SAR Panel should write to the Chief Officer of the organisations involved, providing a template for an IMR
- Organisational reports should be prepared by a senior officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learnt and actions taken or to be taken
- In the case of NHS organisations already completing a Serious Incident Investigation the information produced such as a report, chronology, findings and an action plan should be transferred to the IMR document, within the scope of the terms of reference agreed
- Individual Management Reviews must be signed off by the Chief Officer of each organisation

Multi Agency Chronology

Chronologies are important tools particularly when combined across organisations. This enables a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment.

Many of the methodologies outlined utilise chronologies within them, however, they can be used in isolation to achieve an overview of a case fairly simply, which can assist in assuring or developing multi-agency working.

In this approach each agency produces a single chronology of involvement, over the period that has been agreed as relevant to the investigation or review. They may also be asked to provide chronologies relating to more than one person of interest in the case.

The chronologies are then combined in a desk top exercise. This enables review by an individual, for example, in determining whether there appears to be grounds for further

investigation or potential for learning; or where this is the case, more detailed examination and discussion in a multi-agency workshop. The latter process would usually benefit from a facilitator.

Any identified learning points should be noted and translated into actions which are shared with the SAB and implemented.

Action Learning Approach

This option is characterised by reflective/action learning approaches, which identify both areas of good practice and those for improvement and do not apportion blame. This is achieved via close collaboration partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommend developments.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles, timeframes; specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the presiding procedural guidance via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include members of SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider what happened and why; areas of good practice; areas for improvement and lessons learnt
- Consolidation into an overview report with analysis of key issues; lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to SAB; agree dissemination of learning; monitoring of implementation
- Ongoing monitoring via the SAB

There is integral flexibility within this option as to the scale and therefore costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of an external agency/consultancy can vary from not at all to a full role in documents review, staff interviews and report production. The final decision will be determined by the Safeguarding Adults Board in consideration of the best fit and individual preferences in the light of the case in question.

Peer Review Approach

Peer Led Reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this SAR option regarding the balance of peer team to maximise identified expertise and increase viability. They can be developed as part of regional reciprocal arrangements which identify and utilise skills and enhance reflective practice. Such reviews can be cost effective and spread learning. Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the SAR.

The appointed peer team/panel should agree the Terms of Reference and specific methodology with the SAB.

Multi Agency Practice Learning Review

This approach is suitable where several organisations have been involved in case and it has been determined that there is the potential for learning and/or need to refine or introduce policies and procedures to improve how they can work together in the future, to maximise a repeat of the incident concerned.

The methodology should be proportionate to the incident, however, would normally involve the compilation of a multi-agency chronology, which is used to highlight critical areas for further examination within a facilitated workshop. The review should make best use of all available evidence including any single agency investigation reports and/or safeguarding investigations in order to maximise learning and reduce administrative burden. Normally a suitably qualified Chair from one of the SAB member organisations would lead and facilitate the review and a report author commissioned from within the SAB partners, who is suitably independent to the case to produce a summary report and action plan.

Key priorities are ensuring the participation of all organisations in the coordination of information, participation in the workshop and in implementing the action plan.

Root Cause Analysis

Root Cause Analysis (RCA) is a technique which can be used to uncover the underlying causes of an incident. It looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events working back from the incident itself and identifies a range of factors which contributed to the incident.

This allows the real causes and contributory factors to be identified so that the relevant organisations can learn and put remedial actions in place.

Significant Event Analysis

Significant Event Analysis (SEA) brings together managers and/or practitioners to consider significant events within a case and analyse what went well and what could have been done differently. Its focus is on learning which can lead to future improvements and it results in an action plan with recommendations for learning and development. Staff are brought together in a facilitated team approach.

This methodology has been used for many years in General Practice and in other areas of the NHS. The adult at risk is not involved in SEAs, however, the findings may instigate further review or investigation which should involve them.

It will be for the Chair of the review to decide which methodology suits the case best.

9. JOINT REVIEWS

Where there are possible grounds for a Safeguarding Adults Review and a Domestic Homicide Review or Children's Serious Case Review, Multi-Agency Public Protection Review, Mental Health Service Review and/or other such formal review processes to be undertaken jointly, then a decision should be made at the outset by the decision makers involved as to which process is to lead, who is to take which role and who is to Chair with a final joint report being taken to the necessary commissioning bodies. Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for organisations involved.

Similarly, health services carry out Serious Incidents Requiring Investigation (SIRI) and any relevant investigation should be shared with the Safeguarding Adult Review Panel so that resources and information are made best use of. Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of the NHS funded healthcare (including in the community) that result in: unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past

- Unexpected or avoidable injury to one or more people that has resulted in serious harm

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user, or serious harm

In setting up a Safeguarding Adult Review the SAB should also consider how the process could dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Review or Domestic Homicide Review, a criminal investigation or an inquest.

Any Safeguarding Adult Review will need to take account of a Coroners Inquiry and/or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without impacting on timescales. It will be Chair of the SAR Panel to ensure the necessary contacts are maintained with appropriate people.

10. LEARNING FROM A SAFEGUARDING ADULT REVIEW

In a Safeguarding Adults Review there is a need to achieve an understanding of:

- What happened

- Any errors or problematic practice and/or what could have been done differently

- Why those errors or problematic practice occurred and/or why things weren't done differently

- Which of those explanations are unique to this case and context and what can be extrapolated for future cases to become recommendations for learning

- What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases

A quality assurance process should aim to build on rather than duplicate the work already completed in the course of a review and should understand the analytic techniques and tools used in the particular model being used and the content of any supervision provided as part of that model.

GOOD PRACTICE GUIDANCE:

11. INDEPENDENT ADVOCACY

The Care Act states that an independent advocate must be arranged (where necessary) to support and represent an adult who is the subject of a Safeguarding Adult Review, if it is judged they would experience substantial difficulty in participating in the review process. Where an independent advocate has already been arranged under the Care Act or under the Mental Capacity Act 2005 then, unless inappropriate to do so, the same advocate should be used.

A person assessed as having capacity to make decisions about their care and support may be offered the support of an independent advocate if they would experience 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent them and support them. It will be the responsibility of the local authority to arrange and fund advocacy support in these circumstances.

12. RESPONSIBILITIES TO THE FAMILY

It is vital that families are made aware that the review is taking place and offered the opportunity of contributing to the review process. The Chair of HSAB will contact the family and carers of the adult at risk, as they think is reasonable to invite them to participate in the review process. However, their consent is not required for the review to go ahead. They should be kept updated at key stages of the review and notified of the publication of the report.

Reflecting the principles of openness, transparency and candour; the SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care Act 2014, where an adult has 'substantial difficulty' in participating, this should involve representation and support from an independent advocate (***please see section 11***).

The SAR Panel needs to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how the known abuser might have some input to the review process.

Normally, individuals should be notified that the SAR is taking place. Involvement may be by formal notification only, or by inviting them to share their views in a way that suits them.

The timing of such notification is crucial and particularly where there is criminal justice processes running parallel and decisions will need to be taken in consultation with relevant parties.

If a decision is taken to not involve the adult at risk or their family, the reasons should be informed by legal advice and recorded.

13. RESPONSIBILITY 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. The process and their involvement should be fully explained and for those unfamiliar with the process, they should be signposted to guidance as required.

At the end of the process, HSAB should consider whether staff should be invited to a feedback session, involving representation from the agency/agencies concerned.

Particularly with the systems and methodologies it is key that all agencies ensure there is internal support for those involved. This methodology is highly reflective, very interactive and while the benefits of collaborative analysis is positive, staff can feel challenged by this approach.

14. REPORTING ARRANGEMENTS

The Safeguarding Adult Review Panel will provide regular updates to Halton Safeguarding Adults Board on the progress of the review. The Safeguarding Adult Review should be completed within six months of the review being established. Once completed, the report and recommendations will be presented to the Halton Safeguarding Adults Board for consideration.

Once the report is approved, the Safeguarding Adult Review Panel 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 Safeguarding Adult Board Support Officer. The norm will be to publish an anonymised version of the full report Halton Borough Council Safeguarding Adults webpage and the Halton Safeguarding Adults Board Portal. However, in exceptional circumstances and only with agreement of the Board, this practice may vary.

All Safeguarding Adult Reviews conducted within the year must be referenced within the Board's Annual Report, together with relevant service improvements planned, with timescales and achievements. The Safeguarding Adults Board must include the findings from any Safeguarding Adults Review in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where the Safeguarding Adults Board decides not to implement an action then it **must** state the reason for that decision in the Annual Report.

Safeguarding Adults Review reports should:

- Provide a sound analysis of what has happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- Be written in plain English
- Contain findings and recommendations of practical value to organisations and professionals
- Be suitable for publication
- Be translated into a SMART action plan that can be effectively monitored with clear outcomes

15. COMPLAINTS

The Local Government Ombudsman has jurisdiction to investigate complaints about safeguarding investigations for which the Councils have coordinating responsibility. Although safeguarding investigations are multi-agency in nature this does not preclude the Local Government Ombudsman from investigating matters that relate to the actions of professionals employed by organisations that do not fall within the Local Government Ombudsman jurisdiction.

Depending on the nature of the complaint, the current Local Government Ombudsman practice when receiving a complaint is to consider whether:

- The safeguarding investigation is proportionate
- The Council has taken appropriate action in response to the findings of the safeguarding investigation
- The Council continues to monitor the situation
- The Council can provide evidence why the safeguarding allegations did not meet the safeguarding threshold
- There were any delays or other failures in the process
- Whether the conclusions are consistent with the evidence
- The Council considered all relevant and available evidence

16. INFORMATION SHARING

Record Keeping

Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.

Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:

- What information do staff need to know in order to provide a high quality response to the adult concerned?
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm?
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a third party?

Records should be kept in such a way that the information can easily be collated for local use and national data collections.

All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know.

In order to carry out its functions, SABs will need access to information that a wide number of people or other organisations may hold. Some of these may be SAB members, such as the NHS and the Police. Others will not be, such as private health and care providers or housing providers/housing support providers or education providers.

In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what 'went wrong' and so has hindered them identifying, to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening they must act upon that knowledge, not wait to be asked for information.

SAB may request a person to supply information to it or to another person. The person who receives the request must provide the information to the SAB if:

- The request is made in order to enable or assist the SAB to do its job
- The request is made of a person who is likely to have relevant information and then either:
  - The information requested relates to the person to whom the request is made and their functions or activities
  - The information requested has already been supplied to another person subject to a SAB request for information

Confidentiality

Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review published in 2013:

- Information will only be shared on a 'need to know' basis when it is in the interests of the adult
- Confidentiality must not be confused with secrecy
- Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement
- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk

Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would

justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved.

Decisions about who needs to know and what needs to be known, should be taken on case by case basis, within agency policies and the constraints of the legal framework.

Principles of confidentiality designed to safeguard and promote the interests of any adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies.

Information in a range of media should be produced in different user-friendly formats for people with care and support needs and their carers. These should explain clearly what abuse is and also how to express a concern to make a complaint. Adults with care and support needs and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

If an adult has no appropriate person to support them and has substantial difficulty in being involved in the local authority processes, they must be informed of their right to an independent advocate. Where appropriate, local authorities should provide information in access to appropriate services such as how to obtain legal advice or counselling services, for example. The involvement of adults at risk in developing such communication is sensible.

APPENDIX 1: SAFEGUARDING ADULT REVIEW REFERRAL FORM

Any agency or individual can refer a case for consideration by the Halton Safeguarding Adults Board. This form can be used to refer a case that may meet the criteria for a Safeguarding Adult Review or a case where there are significant and unresolved concerns and the decision making framework for a SAR may be appropriate.

Any referral made or information supplied should be done so in accordance with the relevant legislation, policy and procedure guidance and wherever possible, reference to the Inter Agency Safeguarding Adults Policy, Procedure & Good Practice Guidance and Safeguarding Adult Review Policy.

Details of Referrer	
Name:	
Job Title (if professional referral)	
Organisation (if professional referral)	
Contact Details (include telephone number and email)	
Address:	
Relationship to the adult at risk	
Date referral submitted:	

Details of Adult at Risk	
Name:	
Address :	
Date of Birth:	
Date of death (if applicable)	
Cause of death (if known)	

Ethnicity (if known)	
Name and address of GP	
Details of significant others (include legally recognised next of kin where this is known, family members, carers, advocate, representative)	
Please list any agencies that the person is or has been involved with to your knowledge (for example adult social care, housing, police, voluntary bodies and so on)	

Please provide the details of who you have discussed this referral with including:	
Name:	
Position:	
Organisation	
Relationship to you:	
Date of Discussion:	
Outcome:	
Please include any discussion you may have had with the person subject to this referral (if applicable) or with their significant other(s)	

In addition please provide the following details:	
Brief summary of any evidence/concerns you have about the adult being at risk of abuse and neglect	
Please provide a summary of why you are referring this case for consideration by the Safeguarding Adults Board (please include a brief description of the incident(s) and the impact on the adult at risk, as well as any concerns about the way agencies have worked together)	
Please provide details of any other investigations you are aware of concerning the case (for example serious incidents, criminal, health and safety and safety) **Name and contact details of the Safeguarding Manager or lead person in any other investigation.**	
If the adult at risk is subject to an ongoing safeguarding investigation, please provide additional details (if known) as follows:	
Detail of the initial referral	
Subsequent developments including risk management plans	

Please provide any details that may be useful for this referral	

Please forward this form to SAB Support Officer via secure email using the following address:

IASU@halton.gcsx.gov.uk

You may also post this form to:

FAO Safeguarding Adults Board Support Officer

Oakmeadow Community Support Centre

Peelhouse Lane

Widnes

WA8 6TJ

Please mark it Private and Confidential for the addressee only. Please note that this form contains personal information and should be submitted by secure means.

For completion by the SAB Support Officer	
Date referral received	
Date discussed with the LSAB Chair	
Details of outcome to referrer include date	

APPENDIX 2: PATHWAY FOR CONDUCTING A SAFEGUARDING ADULT REVIEW

Referral for Safeguarding Adult Review

- Written referral for Safeguarding Adult Review submitted to Halton Safeguarding Adults Board via Halton Safeguarding Adults Board Support Officer
- Chair of SAB undertakes initial screening of the referral
- Panel convened to consider referral following initial screening by Chair of SAB
- Panel to make recommendations to SAB whether a SAR should or should not be held
- Chair of SAB makes final decision whether to commission a SAR
- SAB Support Officer contacts referrer to advise them of outcome of the referral

Commissioning a Safeguarding Adult Review

- SAB Chair; Director of Adult Social Services and the SAB Support Officer liaise in order to contact relevant agencies
- Safeguarding Adult Review Panel set up
- Chair of the SAR Panel, facilitator and author identified and appointed as required
- Notify adult and/or family as appropriate
- Consider methodology, scope and timescales of the review
- Consider media and communication strategies

Undertaking a Safeguarding Adult Review

- Safeguarding Adult Review Panel seeks members and confirms involved lead representative. Initial Safeguarding Adult Review Panel held
- Chair of Halton Safeguarding Adults Board approves terms of reference, drawn up by the Safeguarding Adult Review Panel

- Further Review Panels held to consider information provided by involved agencies
- Overview report produced by Independent Author and recommendations presented to the Review Panel
- Overview Report and Executive Summary presented to Halton Safeguarding Adults Board by the Chair of the Safeguarding Adult Review Panel

Public

- Feedback sessions with staff and family facilitated by the SAB Support Officer
- Final report published

Review and Monitoring

- Action plans to be monitored by SAB to ensure the learning supports the development of frontline practice

APPENDIX 3: GUIDANCE FOR FAMILIES

Halton Safeguarding Adults Board – Information for Families about Safeguarding Adults Reviews

What is the Halton Safeguarding Adults Board?

The Halton Safeguarding Adults Board brings together the main organisations that work with vulnerable adults and their families across Halton including the Local Authority, Police, Health Trusts, Probation and Adult Services with the aim of making sure they work in partnership to keep vulnerable adults safe.

What is a Safeguarding Adult Review?

The Halton Safeguarding Adults Board may carry out a Safeguarding Adult Review when a vulnerable adult has been harmed or has died and abuse or neglect is suspected and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future. Safeguarding Adult Reviews look at how local organisations have worked together to provide services to the vulnerable adult(s) who is/are subject to review. A Safeguarding Adult Review is completely separate from any investigation being undertaken by the Police or Coroner.

Who undertakes Safeguarding Adult Reviews?

Safeguarding Adult Reviews are undertaken using different methods, involving people from the various organisations who were involved with the vulnerable adult. There will be a Chair who is independent and someone responsible for writing the final report, known as the Overview Report Author. At the end of the process the final report is produced which is agreed by the Safeguarding Adults Board.

How long will the review take?

The review should be completed within 6 months of the decision being taken to start the Review. Sometimes this timescale needs to be extended.

How are families involved?

Families and, where relevant and appropriate, close friends and carers, will be given the opportunity to share their views and comment on the services they, and the adult at risk received. They will be contacted to offer to arrange a meeting by those undertaking the Review. When the Review is complete there will be a follow on meeting offered to outline the findings and recommendations and families will be provided with a copy of the Executive Summary. This will also be available on the Halton Borough Council Safeguarding Adults webpage and Halton Safeguarding Adults Board Portal.

APPENDIX 4: EXAMPLE TERMS OF REFERENCE FOR SAFEGUARDING ADULT REVIEW PANEL

The Safeguarding Adults Review Panel is accountable to the Halton Safeguarding Adults Board.

1. **Purpose**

To carry out a Safeguarding Adults Review on behalf of the Safeguarding Adults Board and in accordance with Section 44 of the Care Act 2014

2. **Objectives**

- To use the chosen methodology and conduct a Safeguarding Adults Review in the timescale given (within 6 months of initiating it unless good reason for a longer period being required)

- To promote an open, reflective learning culture

- The purpose is NOT to hold organisations (for actions they took in good faith) to account but to learn lessons to prevent similar harm occurring again

- Establish whether there are lessons to be learned from the case under review or that could be under review, about the way in which local professionals and agencies work together to safeguard adults in vulnerable situations

- To establish what those lessons are, how they will be acted upon and what is expected to change as a result

- To enable effective communication with all stakeholders to ensure the learning is widely disseminated and family members are informed and involved in the way they wish to be

3. **Specific Remit/Duties**

a) Promote a culture of continuous learning across all the organisations taking part in the Review

b) Secure compliance with the Safeguarding Adults Board

c) Focus on what needs to happen to achieve understanding, remedial action and answers for family/friends of adults who have died or been seriously abused/neglected

d) Ensure the approach taken to reviews is proportionate according to the scale and level of complexity of issues being examined

e) Conduct the review in a manner that achieves the aim that reviews are trusted and safe experiences that encourage honesty, transparency and sharing information

f) Ensure confidentiality is maintained in relation to information for Safeguarding Adults Reviews

g) Identify learning points from Safeguarding Adults Reviews and report on outcomes to the Safeguarding Adults Review subgroup

h) Put together a draft action plan for the Safeguarding Adults Review Subgroup

4. Chair, Members, Secretary, Deputies

Chair to be nominated by the Safeguarding Adult Review subgroup

Deputy to be nominated

Members to be nominated by the Safeguarding Adult Review subgroup

Meetings to be administered by support officers from the Safeguarding Adults Board

5. Quorum/Voting

The panel acts as a working group to the Safeguarding Adults Board and therefore no voting is required. Any items not resolvable will be discussed by the Independent Chair – Safeguarding Adult Board and the Independent Chair – Safeguarding Adult Review Panel

6. Organisation, Frequency of Meetings, Administration

Meetings to be arranged to fit the work programme of the Safeguarding Adult Review Panel.

Meetings to be administered by support officers from the Safeguarding Adult Board

7. Standing Agenda Items

- Welcome and Apologies
- Minutes and Matters Arising
- Agenda items specific to chosen methodology
- Any other business

APPENDIX 5: CHRONOLOGY TEMPLATE

Anonymised Name	Relationship to subject (if applicable)	Date of Birth	Date of Death (Or Serious Incident)	Address	Ethnicity or diversity needs

CHRONOLOGY OF SIGNIFICANT EVENTS (DATES TO BE AGREED)

Please insert your chronology of significant events during the time period under review, this should include any assessment, referrals and reviews, and should also include decisions made that affected the outcomes for the subject of the review. Each event should be described in as much detail as possible and should be linked to the terms of reference, where this is relevant. If you consider an event outside of the timescale given for the review to be significant you should include this in the chronology and highlight your reasons for inclusion.

Date	Agency	Source of evidence	Name of professional and role	Type of intervention	Action taken/decision made	Comment

AGENCY/ORGANISATION NAME:	IDENTIFY ANY LESSONS LEARNT BY YOUR AGENCY/ORGANISATION: