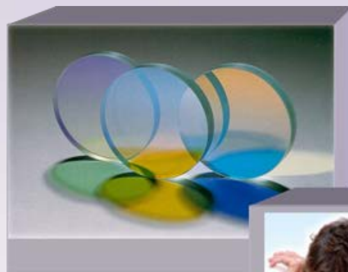
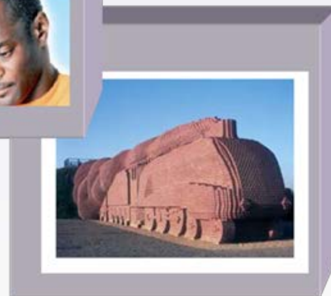
# Safeguarding Adults Review (SAR) Protocol

June 2016





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## 1. INTRODUCTION

1.1 Safeguarding Adults Board (SABs) are a statutory requirement under the Care Act and the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in part 1, section 43 of the 2014 Care Act.

1.2 Darlington SAB 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 that have been involved with an adult at risk have acted. The purpose of the SAR is to identify learning that will bring about improvements so that the likelihood of harm to adults at risk is minimised.

1.3 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) with a view to identify lessons to be learnt from the adult's case, and to apply the learning to future cases. In addition, cases where there is good practice can also be considered to identify learning that can be applied to future cases.

1.4 This procedure specifies the statutory requirements and the working arrangements of Darlington SAB in respect of SARs and alternative learning from case reviews.

## 2. STATUTORY DUTY UNDER SECTION 44 OF THE CARE ACT, 2014

2.1 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.

2.2 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:

> 1) 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;
>
> 2) 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.

2.3 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.

2.4 Each member of the SAB must co-operate 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.

**3. SAR CRITERIA**

3.1 The first criterion for determining whether a SAR should be conducted is in establishing whether the adult was in need of care and support services (whether or not the local authority was meeting any of those needs).

3.2 The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014 (the 'Eligibility Regulations'). The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

3.3 In considering whether an adult has eligible needs for care and support, local authorities must consider whether:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes (which are described in the Care Act guidance sections 6.105 to 6.112)
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

3.4 Significant impact is not defined and should be understood to have its everyday meaning.

3.5 The second criterion to be met is establishing a cause for concern about how the SAB, its member organisations, or other persons with relevant functions, worked together to safeguard the adult. A particular emphasis is the extent that they could have worked more effectively to protect the adult from the resultant outcome and therefore the potential for learning.

3.6 The third criterion involves an examination of the link between the death or (other outcome) and suspected abuse or neglect.

3.7 In the context of SARs, 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 as a result of the abuse or neglect.

**4. LEVELS OF SAFEGUARDING ADULT REVIEW**

4.1. Darlington SAB will utilise two levels of SAR

- A level 1 (Statutory) SAR will be required for those circumstances in which the SAB must arrange a SAR.
- A Level 2 (Discretionary) SAR may be conducted in any other situations

4.2 It is to be noted that the review methodology selected will not be pre-determined by the level of the SAR but after consideration of the particular circumstances of each case, consulting the views of the adult at risk and or relatives and with reference to the purpose and principles. In any SAR the approach should be proportionate to the scale and complexity of the issues and the potential for learning.

## 5. PURPOSE AND PRINCIPLES OF A SAFEGUARDING ADULTS REVIEW

5.1 The purpose of a SAR is to promote effective learning and improvement action, through identifying what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an investigation.

5.2 The SARs purpose is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

5.3 A SAR should highlight any lessons that can be learned from the case and 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.

5.4 SARs will be undertaken in accordance with the following principles:

- **Learning culture:** There should be a multi-agency culture of continuous learning and improvement and to promote good practice
- **Proportionate:** The approach should be proportionate according to the scale and complexity of the issues and the potential for learning
- **Independent:** SARs should be led by individuals who are independent of the case and of the organisations whose actions are being reviewed
- **Transparency:** SARs should be trusted and safe experiences that encourage honesty, transparency and sharing of information.
- **Voice of the user:** Every effort must be made to ensure the voice of the adult at risk or their relatives is evident throughout the process

5.5 The SAB should be primarily concerned with "weighing up" what type of review process best enables this to happen. The level of the review will be determined by the Chair of the SAB following the SAR Screening Panel's recommendation.

5.6 The findings from SAR's will be included in the SAB' s annual report along with relevant service improvements and actions and the reasons for any decisions not to implement actions.

## 6. SAR METHODOLOGY

6.1 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 determined by and proportionate to the specific circumstances and the scale of the situation.

6.2 Any of the methodologies may be used for any type of case. Methodologies that would usually be considered for the most serious cases include traditional serious case reviews (SCR), domestic homicide reviews (DHR), 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 review. There is flexibility in determining the precise process, including variations and combinations of methodology elements on a case by case basis. (See Appendix 1 for additional information on review tools and methodologies).

## 7. INITIATING A SAR

7.1 Only Darlington Safeguarding Adults Board can commission a SAR in Darlington. However any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR.

7.2 Where any individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they may refer a case to the Chair of the SAB via the SAB Business Manager to establish if there are important lessons for multi-agency work to be learnt from a case. This includes any professional body, members of the public, councillors, MP’s and the coroner. The Secretary of State also has authority under the Local Authority Social Services Act (1970) to cause an enquiry to be held where he/she considers it advisable.

7.3 A referral is made by completing the referral form (see appendix 2) detailing why you (as the referrer) believe the case meets the criteria for a SAR. Referrals should be made as soon as it is apparent that the criteria may be met, subject to considerations in paragraphs 7.4 and 7.5 below. An unreasonable delay in raising an issue can impact both on the process and the key purpose in a number of ways.

7.4 The SAB will not normally review cases that are more than twelve months old, unless there is significant information that has more recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. This is in order to ensure the optimum effectiveness and learning from the resources employed.

7.5 Prior to making a referral, professionals working with Adults at Risk, should consider the relevant guidance, and discuss with their organisations line manager, Designated Safeguarding Lead or SAB representative; or the local authority Safeguarding Adult Manager (SAM) or Head of Service (as appropriate).

7.6 By virtue of the criteria, in cases where a SAR may be indicated, a safeguarding concern and/or enquiry may already have been made. In this case a discussion with the relevant safeguarding adult manager should normally take place prior to making a referral for a SAR.

Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to multi-agency safeguarding policy and procedures which considers any immediate protection required.

7.7 However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have died as a result of suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

7.8 All agencies have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning, and this protocol is not intended to duplicate or replace these. However consideration of this protocol must be considered when agencies undertake internal reviews or when investigating serious incidents.

## 8. DECISION MAKING

8.1 On receipt of the SAR referral request, the Business Manager will inform the Director of Adult Social Services (DASS) as the statutory safeguarding lead and the Chair of the SAB. The Independent Chair will consider the information provided prior to triggering the next stage of the SAR screening process. The chair may seek further information including clarity about parallel investigations that may be taking place. In some circumstances, the chair of the SAB may decide not to progress further with a referral at this stage and instead recommend further actions. In this case, the reasons for this will be recorded and a response and explanation provided to the referrer. All referrals will be recorded and noted at the Adult Learning and Improvement Subgroup (ALIG). Attached as appendix 3 is the suggested timeline.

8.2 After the initial screening process, the Chair of the SAB will request that the chair of the ALIG subgroup convenes a screening panel at the earliest opportunity. The ALIG subgroup is a subgroup of the SAB which helps to make sure that learning and development takes place so that people are safeguarded more effectively.

8.3 The Chair of the SAB via the SAB Business Manager will also inform the DASS, Darlington Borough Council. This enables appropriate people to be notified and arrangements to be made to support the process. The chair of the ALIG in consultation with the DASS or relevant delegated senior manager i.e. Assistant Director or Head of Service will confirm the panel membership and the additional information required; the SAB Business Manager and Administrator will organise the panel and will oversee the collation of additional information which the panel will need to consider e.g. chronologies.

8.4 Information requested by the ALIG subgroup may be easily provided by agencies (see appendix 4), or it may be appropriate in certain cases, for agencies who are asked to provide information by the ALIG subgroup to meet in order to consider, gather or discuss information. The relevant SAB and ALIG representatives will be informed of their agencies role and may be required to assist in the coordination of information.

8.5 The SAR screening panel will meet to consider the information in order to make recommendations to the SAB on whether a SAR should or should not be held and on application of the criteria, the level. On conclusion of the meeting, the chair of the ALIG

subgroup will write to the SAB chair (see appendix 5) with the outcome and the rationale on which it is based (within 24 hours or as soon as is practicable).

8.6 Once the Chair of the SAB has received the recommendation, they will make the final decision about whether a SAR should take place. The SAB chair will then notify the Chair of the ALIG and the DASS using the appropriate form (appendix 6) via the Business Manager.

8.7 In the event of the SAB's Chair's decision that a SAR should not take place, the reasons must be recorded and shared with the referrer and the Adult Safeguarding Board. When this is the case and there is a parallel investigation or review process taking place, or if the Chair of the SAB commissions an alternative process, arrangements should be made for the relevant findings to be reported to the SAB via the ALIG subgroup. The ALIG subgroup will then ensure that learning can be disseminated and shared across other agencies and where relevant other regional and national networks.

## 9. THE SAR SCREENING PANEL

9.1 The SAR Screening Panel needs to have the information and expertise required to make the recommendation. It will consist of members of the ALIG subgroup, supplemented with any additional individuals or organisations with the necessary knowledge or expertise pertinent to the circumstances of the case. The SAR Screening Panel may also wish to have available specialist advisers whose role will be to advise it during the process.

9.2 The SAR Screening Panel will be provided with written reports from the key agencies involved. Representatives from agencies may also be asked to attend during the first part of the panel meeting, to help clarify the circumstances of the case. It is important for the panel to have sufficient information before discussion begins. However the panel is not investigating the circumstances of the incident, and is not conducting the SAR themselves, so the consideration of issues should be proportionate.

9.3 After reviewing all the information available against the criteria and guidance, the SAR Screening Panel will determine if they consider that the criteria for a SAR has or has not been met.

9.4 If it is agreed that the SAR criteria is met, the Panel will give a recommendation as to what review type would be the most appropriate and proportionate in the given circumstances. The SAR Screening Panel may also make recommendations on the review methodology and whether an independent chair and/or author are required. In considering their recommendations the Panel must also consider other issues pertinent to the review such as media interest but with the priority being the engagement and seeking views of the individual and/or their families members whichever is appropriate, in doing so the individual and/or family members should have access to advocacy support and representation in accordance with the Care Act guidance. As part of the engagement process, it would be expected that the ALIG Chair or most appropriate person to visit the adult at risk or parents/carers to inform them of the recommendations of the SAR panel and agree how they can be involved in the process if they wish.

9.6 If the SAR Screening Panel considers a SAR should not be held, they may recommend that another form of review or investigation is appropriate. This could include a single agency review or a smaller scale audit of agency involvement. This might be the case where for instance there is a safeguarding element and lessons to be learnt regarding the conduct of an agency but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.

**10. COMMISSIONING A SAR**

10.1 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 (this is from the point the SAB Independent Chair agrees with the ALIG recommendation to proceed with a SAR refer to para. 8.6), unless there are good reasons for a longer period being required.

10.2 On receipt of the SAB Chair's decision to undertake a SAR, the DASS and the Chair of the ALIG subgroup 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 (required for all SAR level 1 and may be required for SAR level 2, depending on the scale and complexity)
- Identifying appropriately qualified and experienced leads (chair, facilitator and 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

10.3 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 and the Chair of the SAB.

**11. THE SAR PANEL**

11.1 In all SARs, there must be clear accountability for implementing and assuring the arrangements, disseminating the learning and implementing agreed actions (appendix 7 sets out the stages of a SAR process). In most cases a SAR Panel will be required to undertake and oversee the review and report to the SAB. 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 Care Act statutory agencies.

11.2 The panel and the other arrangements should be proportionate to the circumstances of the case and the review methodology. For smaller scale reviews such as a multi-agency practice review, a root cause analysis, or a significant event review, then the ALIG subgroup may be the most appropriate panel. For more complex and high profile situations, the panel will be drawn from a wider group of individuals and organisations with the relevant experience and expertise. For these cases, an independent chair and author may be appropriate. Whether the chair, author and as required facilitator/reviewer are internally or externally appointed they should have the experience and expertise required; and independence from the case and the actions being reviewed.

11.3 SAR Panel's will set their own meeting schedule and timings appropriate to the case and the methodology; and report this to the SAB. Whilst the frequency and number of meetings may vary, the SAR Panel will need to meet a minimum of 3 times in order to establish, monitor and finalise the review.

11.4 In Darlington, the SAB will exercise its function of having oversight of the actions via the ALIG subgroup. The ALIG subgroup will ensure that identified actions are completed, and any barriers or slippage in achieving outcomes are responded to.

## 12 INTERFACE WITH OTHER REVIEWS AND INVESTIGATIONS

12.1 There are a number of types of review and investigation that may interface with a SAR and it is important to identify any other processes which may be running in parallel or being considered. These include a Child Serious Case Review (SCR), Domestic Homicide Review (DHR), safeguarding and serious incident investigations, disciplinary processes, judicial reviews, complaints, criminal justice processes and Coroner inquests. The criteria for a serious incident in the NHS is described in 12.5 below.

12.2 In setting up a SAR, the SAB must consider how the SAR will dovetail with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning; and minimising the impact on those affected by the case.

12.3 Where there are possible grounds for both a SAR and a Child SCR or a DHR then a decision should be made at the outset by the respective decision making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one board leading, with the same or different reports being taken to each commissioning body.

12.4 Any SAR will need to take account of a coroner's enquiry and, or any criminal investigation including disclosure issues, which may impact on timescales. It will be the SAR lead's role – usually the Chair of the SAR Panel to ensure the necessary contacts are maintained with appropriate people.

12.5 Serious Incidents in the NHS include: (Serious Incident Framework NHSE 2015)

- Acts and/or omissions occurring as part of 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;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare is not taking appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
- This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.
- In the event of the aforementioned occurring the incident would necessitate in completion of serious incident reporting and investigation.

## 13 CONSULTING WITH THE ADULT AT RISK AND OTHERS AFFECTED BY THE REVIEW

13.1 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, where an adult has “substantial difficulty” in participating, this should involve representation and support from an independent advocate or their family member/friend where appropriate.

13.2 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 a known abuser might have some input to the review process.

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

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

13.5 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.

13.6 Under the 2014 regulations of the Health and Social Care Act providers are required to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. This ‘duty of candour’ also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

13.7 If an adult affected by a notifiable patient safety incident, has died or experienced serious abuse or neglect (see section 3) then a conversation with the family/adult should be considered prior to a referral for a SAR. If a SAR is commissioned subsequently then they should be kept updated on developments from the investigation into the patient safety incident and the SAR.

## 14. **CONSIDERATIONS FOR DISCLOSURE IN A SAR**

14.1 The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the ‘right to know’, came into force in January 2005

- Consideration of relevant articles of the European Convention of Human Rights, as incorporated into the Human Rights Act (1998)
- There are ‘absolute’ and ‘qualified’ exemptions under the Act. Where information falls under ‘absolute exemption’, the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a ‘qualified exemption’ or ‘exception’ it must apply the ‘public interest test’
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act (1998) and Children Act (1989) (updated 2004).
- Information sharing between SABs and the Coroner is not defined in statute however case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the SAB has commissioned a SAR information sharing in relation to SAR documents should be considered on a case by case basis. On receipt of a request for documents relating to a SAR, from the Coroner, the SAB will seek legal advice in order to consider Public Interests Immunity arguments.
- Chapter 14 of the Care Act Guidance sets out expectations in relation to information sharing between agencies and SAB’s in relation to SAR’s, including an expectation that information must be shared to enable a SAB to do its job.

**Appendix 1**

## SAR METHODOLOGIES AND TOOLS

### Traditional model

This methodology, a traditional model, forms the basis of DHR and SCR in similar fields and historically in adult safeguarding. Typical features include:

- Appointment of a panel, including chair (usually independent) and core membership- which determines terms of reference and oversees process
- Independent report author
- Combined chronology of events (see below)
- Involved agencies produce Individual Management Reports(see below), 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 (IMR)

IMR's 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 the 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
- IMRs 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, that 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. This latter process will usually benefit from a facilitator.

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

**Advantages and disadvantages of traditional review approach**

The relative merits and drawbacks of a traditional methodology are outlined below.

Advantages:

- More familiar to SAB/stakeholders, who may consider it more robust/objective
- Where public/political confidence may only be assuaged via a tried and tested approach
- Where there is multiple abuse or high profile cases/serious incident
- Methodology is likely to be compatible with a Children SCRs/DHR

Disadvantages:

- Can be overly bureaucratic
- Experience of protracted-implementation of lessons learnt/recommendations and may not be sufficiently responsive to time considerations
- Costly-costs may not justify the outcomes
- More likely to be perceived as attributing blame
- Frontline staff often precluded, so disengagement from process and subsequent learning

**2. 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 collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

**The broad methodology is:**

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); 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 from 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
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the SAB

**Further variance**

There is integral flexibility within this option as to the scale and thus 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 external agency/consultancy can vary from not at all to a full role in documents review, staff interviews and report production.

The table below is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the SAB in consideration of the best fit and individual preferences in the light of the case in question.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Health and Social Care Advisory Service (HASCAS)
- Paul Tudor-Significant Incident Learning Process
- Social Care Institute for Excellence (SCIE) - Learning Together Model

Although embodying slight variations all of the above models are underpinned by action learning principles.

**Advantages and disadvantages of action learning review approach are outlined below**

The relative merits and drawbacks of this review approach are outlined below:

Advantages:

- Significant evidence approach is much more efficient
- Swiftness of conclusion and embedding the learning

**Action learning approach enhances:**

- Partnership working
- Mutual recognition of alternative partner perspectives
- Collaborative problem solving
- Involvement of both frontline staff/senior managers secures both strategic and operational perspectives.
- Unique perspective of staff involved in the case, reflective of the systems operating at the time
- Approach allows for identification of system strengths/positive practice
- Learning take place through the process and there is enhanced commitment to its dissemination

Disadvantages:

- Methodology less familiar to many

**3. 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 can 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.

**Advantages and disadvantages of peer review approach**

The relative merits and drawbacks of this review approach are outlined below.

Advantages:

- Objective - independent perspective to particular case/aspects of safeguarding practice
- Usually via trusted sources sharing common experiences/understanding
- Can be part of reciprocal arrangements across/between partnership
- Very cost effective, usually no fees incurred

Disadvantages:

- Capacity issues within partner agencies may restrict
- Availability
- Responsiveness
- Where political or high profile cases deems local oversight is preferable

**4. Multi agency practice learning review**

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

**5. Root Cause Analysis (RCA)**

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.

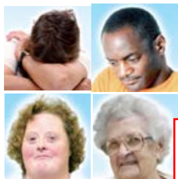
**6. Significant Event Analysis (SEA)**

This method brings together managers and/or practitioners to consider significant events within a case and analyse together 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.

**Appendix 2**

**Referral to the Darlington Safeguarding Adults Board**



# Adult Learning & Improvement Group – Referral Form

## Section 1 - Agency/Professional Details:

| Referrer Name: | | Date Submitted: | |
|---|---|---|---|
| Referring Agency Name:<br>(if applicable) | | Authorising Officer:<br>(SAB member/Senior Mgr) | |
| Referring Agency Address: | | | |
| Referrer Contact Number: | | Secure e-mail contact: | |

## Section 2 - Adult at Risk Details:

<table>
<tr><td>Family Name:</td><td></td><td>Forename:</td><td colspan="2"></td><td>Preferred Name:<br>(record any ‘alias’ if known)</td><td colspan="2"></td></tr>
<tr><td>Date of Birth:</td><td></td><td colspan="3">Male ☐ Female ☐</td><td>Mental Capacity[1]:</td><td>Yes ☐</td><td>No ☐</td></tr>
<tr><td>Address:</td><td colspan="4"></td><td>Contact Number:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Please list any ‘unique id numbers’ known e.g. Carefirst, PARIS ID:</td><td colspan="5"></td></tr>
</table>

[1] Does the adult at risk have capacity to make their own decisions? Is there an Advocate, Independent Mental Capacity Advocate, Independent Mental Health Advocate involved? Record details in Section 3 – Professional Involvements

**Section 3 - Professional Involvements[2] (record as much detail/knowledge of any involvements):**

| GP: | | GP Practice: | | Address & Contact Detail[3]: | |
|---|---|---|---|---|---|
| Social Worker/Care Manager: | | Address & Contact Detail: | | | |
| Community Psychiatric Nurse: | | Address & Contact Detail: | | | |
| Consultant Psychiatrist: | | Address & Contact Detail: | | | |
| Probation Officer: | | Address & Contact Detail: | | | |
| Children's Services Social Worker: | | Address & Contact Detail: | | | |
| Domestic Violence Worker: | | Address & Contact Detail: | | | |
| Housing Officer: | | Address & Contact Detail: | | | |
| Advocate Details: | | Address & Contact Detail: | | | |
| Other Involvement[4]: | | Address & Contact Detail: | | | |
| Other Involvement: | | Address & Contact Detail: | | | |

[2] THIS WILL ASSIST WITH IDENTIFYING AGENCY INVOLVEMENT FOR THE ADULT LEARNING & IMPROVEMENT GROUP.
[3] RECORD SECURE E-MAIL ADDRESSES FOR PROFESSIONAL INVOLVEMENTS IF KNOWN.
[4] RECORD ROLE AND ORGANISATION DETAIL IF KNOWN.

## Section 4 – Personal Relationships/Associated People:

| Please record all personal involvements/relationships including relationship type, for example, next of kin, spouse/partner, ex-spouse/partner, sibling, neighbour, children within household, etc. | | | | | |
|---|---|---|---|---|---|
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |
| Full Name: | | Address & Contact Detail: | | Relationship: | |

## Section 5 – Reasons for Consideration for Safeguarding Adult Review or an alternative learning from multi-agency practice review:

<table>
<tr><td colspan="4">Do you feel this case meets the criteria for an SAR in line with Section 44[5] of the Care Act 2014 – if so why? Describe from your view referring to the SAR criteria why you believe this case meets the threshold for a SAR and refer to section 3 of the procedure. Alternatively if you are not considering the case for a SAR but want the case to be considered for an alternative multi-agency learning review, again explain why and what learning you hope to get from this?<br><br>Record your narrative inclusive of Date, Details of Event, Agencies involved at the time, nature of abuse and/or injuries sustained and any person(s) alleged to have caused abuse or neglect, including your reasons for the request[6]. Please record any details that are pertinent to safeguarding processes and/or involvement and any subsequent actions/recommendations from that process if known.</td></tr>
<tr><td>Case to be considered for a SAR:</td><td></td><td>Case to be considered for an alternative learning from multi-agency practice review:</td><td></td></tr>
<tr><td colspan="4"></td></tr>
</table>

[5] Care Act Section 44
[6] Care and Support Statutory Guidance

<table>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">SAB INDEPENDENT CHAIR DECISION: As per para. 8.1 and 8.2 of the procedures the SAB Chair is to summarise his decision and how he came to that decision including how he would like the ALIG Subgroup Chair to Proceed.</td></tr>
<tr><td>Do you recommend this case for a SAR</td><td>Yes ☐</td><td>No ☐</td></tr>
<tr><td colspan="3">Summarise how you came to that decision:</td></tr>
<tr><td colspan="3">What are your recommendations for the ALIG Chair (e.g. SAR, alternative review or no further action):</td></tr>
</table>

**Section 6 – Receiving Officer (Business unit use ONLY)**

| DATE REFERRAL RECEIVED: | DATE SAB CHAIR NOTIFIED:<br>DATE SAB CHAIR RECEIVED THE REFERRAL FORM: |
|---|---|
| SAB CHAIR DECISION RECEIVED BY THE BUSINESS UNIT | ALIG CHAIR INFORMED OF THE DECISION |
| SAR SCREENING PANEL (DATE): | ALIG MEETING (DATE): |

**Appendix 3**

## TIMELINE TO FOR DECISION MAKING AND INITIATING A SAR

| Week | Description | Responsible person/s |
|---|---|---|
| 1 | Referral made to the Business Unit for a SAR consideration | Referring Agency |
| 1 | Referral to be logged on the system and emailed securely to the SAB Independent Chair and DASS. | Business Manager |
| 2 | SAB Independent Chair to inform the ALIG Chair via the Business Manager of his/her decision | Business Manager |
| 2 | If decision to proceed with the SAR consideration – SAR panel to be convened<br><br>If not SAR and to consider an alternative review, referral to be added to the next ALIG agenda for consideration | ALIG Chair and Business Manager |
| 3/4 | Business Unit to request completed chronologies from agencies involved with the adult at risk in advance of the SAR panel | All identified agencies and Business Unit |
| 5 | SAR Panel held and ALIG Chair to write to SAB Independent Chair to advise of panel's decision (ideally within 24 hours or as soon as practical) | ALIG Chair |
| 6 | Independent Chair to write to ALIG Chair and DASS with final decision via the Business Manager | SAB Independent Chair |
| **SAR process to commence and 6 month timeline starts** | | |
| **Refer to para. 10 of the procedures and appendix 6 for commissioning a SAR** | | |

**Appendix 4**

**CHRONOLOGY TEMPLATE FOR SAR SCREENING PANEL**

# Multi-Agency Chronology Template

| Name of Adult | |
|---|---|
| Date of Birth | |
| Address | |
| Carefirst Reference Number | |
| NHS Number | |
| Agency | |
| Author | |

| Date & Time (dd/mm/yyyy) | Significant Event/Contact | Staff Member details | Staff Member Job Title | Any actions taken |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Appendix 5**

**SAFEGUARDING ADULT LEARNING AND REVIEW CRITERIA PANEL**

**HELD ON {INSERT DATE}**

**RECOMMENDATIONS TO DARLINGTON SAFEGUARDING ADULTS BOARD**

<table>
<tr><td rowspan="2">Name of Adult:</td><td colspan="2">DOB:</td></tr>
<tr><td>DOD:</td><td>Age at Death:</td></tr>
<tr><td colspan="3">Recommendations from the ALIG Panel<br>(To include any additional recommendations from the ALIG Panel: including consideration of the need for an independent author and/or chair, timescales, family/relevant person contact and representation or involvement, agencies to be involved, communications and media elements) To also include any contrary of dissenting views.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Reason for recommendations to include type of review if level 1 SAR not recommended:</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Comments/confirmation from DSAB Chair</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Date:</td><td colspan="2">Sign by:<br>(ALIG Chair)</td></tr>
<tr><td>Date sent to SAB Ind. Chair:</td><td colspan="2">Date sent to the DASS:</td></tr>
</table>

<table>
<tr><td colspan="3">Members who attended the panel and were part of the decision making:<br>(recommended as a minimum the SAB statutory agencies: Police/CDDFT/CCG/DBC)</td></tr>
<tr><td><u>Name</u></td><td><u>Job title</u></td><td><u>Organisation</u></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

**Appendix 6**

## STAGES OF A SAFEGUARDING ADULT REVIEW

### STAGE 1

The Panel will have responsibilities from the outset to:

- Specify the terms of reference[7]
- Set timescales, if not already determined
- Confirm the lead roles such as chair, facilitator, reviewer, author and planned methodology
- Link to other interested parties such as the Crown Prosecution Service (CPS) 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 (IMRs) or Agency Report Forms 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 the 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

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[7] The exact requirements will depend on the methodology agreed for the review; for instance not all methods require IMRs as part of the process.

- 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)
- Commission the dissemination of the review or 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