

**Buckinghamshire Safeguarding Adults Board**

**Safeguarding Adult Review Policy**

**(SARs)**

**Document Control**

**Ratified by Buckinghamshire Safeguarding Adults Board**

**Date Revision Due** Oct 2024

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| **Revision History** | **Changes made** | **Author** |
| December 2020 | Change of BSAB log and updates to sections 7/8/10 &13 to reflect new working practices | Vince Grey Safeguarding partnership Manager |
| October 2022 | Grammar and formatting.  10.1, 13.1, 13.9 to reflect new working practices.  4.8, 4.9 to reflect change from SCR to LCSPR | Ashleigh Coneron  Safeguarding Practice Review Officer  BSAB |

**1. Introduction**

* 1. These procedures are designed for inter-agency use in the protection of adults with care and support needs, and to ensure compliance with The Care Act 2014, and the Care and Support Statutory Guidance issued under the Care Act 2014 which states that:-

*“A Safeguarding Adults Board 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:-*

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

*(b) condition 1 or 2 is met.*

*Condition 1 is met if—*

*(a) the adult has died, and*

*(b) the Safeguarding Adults Board 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).*

*Condition 2 is met if—*

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

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

*A Safeguarding Adults Board may 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).*

*Each member of the Safeguarding Adults Board 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”*

(Care Act 2014, section 44)

* 1. The Act makes provision for a range of methodologies and places a requirement on Buckinghamshire Safeguarding Adults Board’s member agencies to cooperate with and contribute to a Safeguarding Adult Review (SAR).
  2. Buckinghamshire Safeguarding Adults Board has an established a Safeguarding Adults Review Sub-Group which is responsible for gathering information, making recommendations to the Buckinghamshire Safeguarding Adults Board chair on whether the Safeguarding Adult Review criteria is met, agreeing and managing the process and assuring the Buckinghamshire Safeguarding Adults Board that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies as required.

**2. The Purpose of a Safeguarding Adult Review**

2.1 A Safeguarding Adult Review is a multi-agency Review process which seeks to determine what relevant agencies and individuals involved could have done differently that may have prevented harm or a death from taking place. The Safeguarding Adult Review will look at;

* The lessons that can be learnt from the case about the way in which local professionals and agencies work together to safeguard adults
* how those lessons can be applied to future cases to prevent similar harm occurring again.
* to highlight examples of good practice

2.2 A Safeguarding Adult Review is not an inquiry into how an adult died or suffered or who is culpable. It is not a reinvestigation of the case and a Safeguarding Adult Review does not seek to apportion blame or hold individuals to account. There are other processes that exist for these purposes;

* Criminal proceedings
* Disciplinary processes
* Employment law
* Professional regulations such as Care Quality Commission, NMC, H&CPC and the General Medical Council.

2.3 It is vital, if individuals and organisations are to be able to learn lessons from the past, that Reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain the maximum benefit from them. If individuals and their organisations are fearful of Safeguarding Adult Reviews, their response will be defensive and their participation guarded and partial.

2.4 It is acknowledged that organisations will have their own internal/statutory review processes to investigate Serious Incidents and Safeguarding Adult Reviews are not there to replace those processes. Such reviews/investigations can be used alongside and contribute to a Safeguarding Adult Review and can be considered as an alternative option for reviewing a case should a request for a Safeguarding Adult Review not be deemed to meet the criteria, but it is felt that something can be learned.

1. **Principles of a Safeguarding Adult Review**
   1. SAR’s should reflect the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. Safeguarding Adults Review’s should also be person centred and reflect the “Making Safeguarding Personal” approach embedded in the Care Act 2014.
   2. Buckinghamshire Safeguarding Adults Board and partner organisations should also apply the following principles when carrying out all reviews.

* The adult with care and support needs should be supported to be involved in the Safeguarding Adult Review and advocacy should be arranged if required.
* 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
* The approach taken to Reviews should be proportionate according to the scale and level of complexity of the issues being examined.
* Professionals should be involved fully in the Reviews and invited to contribute their perspectives without fear of being blamed for actions which they took in good faith.
* There should be continuous learning throughout the whole process and actions should be put into place as identified not just at the formal end of the process.
* Buckinghamshire Safeguarding Adults Board is responsible for making sure that the Safeguarding Adult Review takes place in timely manner and seek assurance of the completion of the appropriate improvement action.

**4. Criteria for conducting a Safeguarding Adult Review**

4.1 Whether to undertake a Safeguarding Adult Review and the process used should be determined according to the specific circumstances of the individual or cases. The methodologies for undertaking any review should be determined by the Safeguarding Adult Review Sub-Group as being the **best and most proportionate** method of achieving the **best outcome**.

4.2 Safeguarding Adults Boards must arrange a Safeguarding Adult Review when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

4.3 Safeguarding Adults Boards must also arrange a Safeguarding Adult Review if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

4.4 The Buckinghamshire Safeguarding Adults Board should also consider the justification for a Safeguarding Adult Review in other situations when it believes there will be value in doing so. This may be where a case can provide valuable insights into the way that organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring example of good practice. This may be where there is;

* Clear evidence of a risk of significant harm to an adult with care and support needs unrecognised by organisations or individuals in contact with the vulnerable adult or perpetrator, **or** not shared with others **or** not acted upon properly
* At least one agency considers its concerns were not taken sufficiently seriously, or acted upon appropriately by another person/agency.
* The case indicates that there may be failings in one or more aspect of the local operation of formal safeguarding procedures which extend beyond the handling of the individual case
* The case appears to have implications for a range of agencies or professionals
* The case suggests that there may be a need for the Buckinghamshire Safeguarding Adults Board to change its protocols or procedures, or that they need to be more effectively promoted, understood or acted upon.

4.5 The adult who is the subject of the Review need not have been in receipt of care and support services.

4.6 If the Buckinghamshire Safeguarding Adults Board decides to conduct a Safeguarding Adult Review where another authority is involved, the Chair of Buckinghamshire Safeguarding Adults Board will inform the Chair of that authority’s Safeguarding Adults Board. Together they must agree whether the Safeguarding Adult Review should be conducted as:

1. A Buckinghamshire Safeguarding Adults Board Review with input from the other Safeguarding Adults Board, or
2. A joint Review where members of each panel work together as an expanded panel.

4.7 This decision will depend on the complexity of the case and the degree of involvement of each partnership. Should the Chairs be unable to agree, the matter must be referred to the respective Chief Executives for a decision, or failing that to the Care Quality Commission.

4.8 In relation to links with other reviews, there are separate statutory review requirements for **Domestic Homicide Reviews and Local Child Safeguarding Practice Reviews.** There will be circumstances where a Safeguarding Adult Review and a Domestic Homicide Review or Local Child Safeguarding Practice Review is required because they concern the same source of risk etc. Consideration should be given to how the processes can be managed in parallel in the most effective manner to enable organisations and professional to learn from the case. This could involve joint arrangements for some aspects of the Review or a joint Review with key lines of enquiry relevant to the Safeguarding Adult Review.

**5. Coroner’s Inquests**

* 1. A Coroner’s court is a legal body that helps to determine how, when, and why a person died, but not who is responsible. The investigation is held in public at a Coroner’s court where:
* A death was sudden, violent or unnatural; or
* A death occurred in prison, police custody or whilst on a Deprivation of Liberty authorisation or
* The cause of death is still unknown after a post-mortem.
  1. A Safeguarding Adult Review must take into account any Coroner’s inquiry or criminal investigation related to the case to ensure that the relevant information can be shared without incurring significant delay in the Review process. The Chair of the Sub-Group will liaise with the Coroner regarding any relevant Safeguarding Adult Review referrals.
  2. When the Coroner has decided that an inquest will be held on a case where a Safeguarding Adult Review is taking place, relevant information should be shared. The Chair of the Sub-Group will share the draft or final overview report with the Coroner in order to contribute to the inquiry.

1. **Duty of Candour**
   1. All members of Buckinghamshire Safeguarding Adults Board are expected to create a culture of openness, transparency and candour within their day to day work and with the Board.
2. **Making a Referral for a Safeguarding Adult Review**
   1. Buckinghamshire Safeguarding Adults Board is the only body which can commission a Safeguarding Adult Review within Buckinghamshire. There is no restriction as to who can submit a referral for a Safeguarding Adult Review. It is generally expected that any referral is discussed and agreed with the agency safeguarding lead prior to submission but this is not essential.
   2. There is a referral form which is available on the Board’s website. The referral document should be submitted as soon as the Safeguarding Adult Review criteria appear to have been met. The referrer should provide all relevant available information. It is important to note all the agencies that are known to have been involved in the case, this will enable further scoping to be undertaken.
   3. The process for defining the need for a Safeguarding Adult Review has been changed to reflect new working practices within the Business Unit for the Safeguarding Adults Board. All new referrals from April 2020 will be reviewed through a rapid review panel*.* All referrals will be received in the usual manner and then reviewed by the three statutory agencies within the partnership i.e. Thames Valley Police (also performing the Chair role for the Safeguarding Adult Review Sub-Group), The Integrated Care Board and Buckinghamshire Council. They will be supported by the Safeguarding Partnership Manager whose responsibility it will be to convene the rapid review panel. This will take place at the earliest opportunity.

Once the panel have reached a final decision this will need to be ratified by the Independent Chair for the Safeguarding Adults Board. This decision will also be communicated to the Safeguarding Adult Review Sub-Group and the individual/agency submitting the referral.

If a referral is received within a seven-day period of the next Safeguarding Adult Review Sub-Group meeting the Safeguarding Partnership Manager may defer the review of the referral to that meeting and forego the rapid review panel.

7.4 Completed referral forms should be forwarded to the Chair of the Safeguarding Adult Review Sub-Group via the Safeguarding Partnership Manager. Referrals can be made via email to [bsab@Buckinghamshire.gov.uk](mailto:bsab@Buckinghamshire.gov.uk)

1. **Screening the Referral**
   1. On receipt of the referral this should be initially placed on the Safeguarding Adult Review log held within the Business Unit and then reviewed by either the rapid review panel or SAR Sub-Group. Either the rapid review panel or SAR Sub-Group can return the initial referral document to the referring individual/body for further information to be obtained if it will assist in a more informed and timely decision being made.
   2. At the **discretion** of the Chair of the Safeguarding Adult Review Sub-Group, an electronic notification will be sent to all Sub-Group members alerting them to the potential for a Safeguarding Adult Review. Members will confirm receipt of this notification and make arrangements for all relevant records within their organisation’s to be identified and sealed if decided this is appropriate.
   3. Following a referral, the Chair of the Safeguarding Adult Review Sub-Group may defer the decision to hold a rapid review process and request that the referral is taken to the SAR Sub-Group if they feel that the wider knowledge base of the panel of professionals that constitute the SAR Sub-Group is the most appropriate place to make a decision as to whether to start a Safeguarding Adult Review.
   4. Following receipt of the referral and any further information requested by the rapid review panel or SAR Sub-Group the rapid review panel or SAR Sub-Group will consider whether the criteria for a Safeguarding Adult Review have been met. **The process should aim for a consensus, not a majority view, it is a multi-agency Review therefore there is a need for all the agencies to sign up to the Review taking place and therefore embedding the learning.**
   5. The recommendation of the Safeguarding Adult Review Sub-Group must be forwarded to the Chair of the Buckinghamshire Safeguarding Adults Board, who has ultimate responsibility for deciding whether or not to conduct the Review.
   6. If the decision is to precede, the Safeguarding Adult Review Sub-Group will then commission the Review and request that a Panel be formed, with the Chair for the Panel ideally identified as an existing member of the SAR Sub-Group. However, should a different approach be identified then a member of staff from another agency might be able to chair the Review Panel.
   7. At the same time a letter will be sent to the referrer informing them of the outcome of the referral as well as letters notifying the adult and or family of the outcome of the referral and a leaflet explaining the process of a Safeguarding Adult Review.
   8. Members of the Review Panel have a dual role; to represent professional or organisational views in relation to information brought before the Safeguarding Adult Review Sub-Group and to act collectively in representing well-evidenced, best practice standards.

8.9 Each Review Panel must therefore also consider co-opting additional representatives to ensure that each review is informed and directed by those deemed relevant to each case.

8.10 In selecting representatives each agency must choose someone who:

* Is able and has an explicit mandate to represent the organisation’s views, policies and practice appropriately.
* Has sufficient experience and knowledge of the field to inform the debate and the matters under consideration, and
* Is of sufficient authority or seniority to ensure that recommendations arising from the review are addressed within their agency.
* Has not been involved directly in working with or managing the case being reviewed.
* Will be able to commit the time necessary to contribute to the Review.

1. **Appeals Against the Decision**
   1. If any Buckinghamshire Safeguarding Board member, involved agency or person disagrees with the decision made on behalf of the Board following a referral for a Safeguarding Adult Review, then an appeal against that decision can be made. The appeal should be made in writing to the Chair of the Board via the Safeguarding Partnership Manager. The appeal should include the rational for undertaking the Review and any additional information relating to the case.
   2. Following receipt of the appeal the Chair of the Board and another member of the Board will review the decision and a response to the appeal will be made by letter.
   3. A complaint can also be made to Buckinghamshire Council’s Complaints Department and ultimately to the Local Government Ombudsman.
2. **Conducting a Safeguarding Adult Review**

10.1 When a case has been approved by the Safeguarding Adult Review Sub-Group an Independent Reviewer will be sourced, this process will be overseen by the Safeguarding Partnership Manager with a view to being more transparent and ensuring an open process takes place. The Independent Reviewer will then come to a meeting with the Panel to start to draw up the Terms of Reference for the Review as well as identifying with the Panel members any issues of relevance. Relevant issues might include:

* When should the Review process start and by what date should it be completed? N.B. The target for each review should be for completion of a Safeguarding Adult Review within 6 months of initiating it.
* How the adult who is the subject of the Review and/or family members/carers should contribute to the Review, and who should facilitate their involvement? What are the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
* Is the process proposed by the Sub-Group still the right process?
* Are there features of the case which indicate that any part of the Review process should involve, or be conducted by, a party independent of the professionals/organisations that need to participate in the Review?
* Would it help the Review Panel to bring in an outside expert at any stage to shed light on crucial aspects of the case?
* How are the adult and or their family going to be involved in the process?
* Over what time period should events be reviewed, i.e. how far back should enquiries go, and what is the cut-off point?
* What family history/background information will help to better understand the present?
* Which organisations and professionals should contribute to the Review?
* Is there a need to involve organisations/professionals in other SAB areas, and what should be the respective roles and responsibilities of other SAB’s with an interest?
* How should the Safeguarding Adult Review process take account of a Coroner’s inquiry, and any criminal investigations or proceedings related to the case? *Seek advice from police regarding potential conflict with ongoing police investigation*
* What is the best way to liaise with the Coroner and/or the Crown Prosecution Service?
* How should the Review process fit in with other Reviews?
* Who will make the link with relevant interests outside the main statutory organisations e.g. independent professionals and voluntary organisations?
* When should the Review process start and by what date should it be completed?
* How should any public, family and media interest be handled, before, during, and after the Review?
* Does the Buckinghamshire Safeguarding Adults Board need to obtain independent legal advice about any aspect of the proposed Review?

10.2 Some of these issues may need to be revisited as the Review progresses and new information emerges.

10.3 More than one Reviewer may be commissioned if the SAR in question requires a range of expertise beyond the scope of one Reviewer. If this is the case one of the Reviewer’s commissioned will be designated the Lead Reviewer and will prepare the final written SAR report.

**11. Timescales**

11.1 Reviews will vary widely in breadth and complexity. In all cases, lessons should be learned and acted upon as quickly as possible.

11.2 Reviews should be completed within six months, unless an alternative timescale is agreed.

11.3 Sometimes the complexity of a case does not become apparent until the Review is in progress. As soon as it emerges a review cannot be completed within six months of the Chair’s decision to initiate it, the Chair of the Buckinghamshire Safeguarding Adults Board must agree a timescale for completion.

11.4 In some cases, criminal proceedings may follow the death or serious injury of a vulnerable adult. Those co-ordinating the Review should discuss with the relevant criminal justice agencies how the Review process should take account of such proceedings e.g. how does this affect timing, the way in which the Review is conducted (including interviews of relevant personnel), who should contribute and at what stage?

11.5 Safeguarding Adult Reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. However, the views of the police and crown prosecution service should always be sought.

11.6 In some cases it may not be possible to complete or to publish a Review until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons from being implemented.

**12. Who should be involved in the Safeguarding Adult Review?**

12.1 Initial scoping of the Review should identify contributors, though it may emerge as information becomes available that the involvement of others would be useful - in particular, information of relevance to the review may become available through criminal proceedings.

12.2 Each relevant service should designate an appropriate professional to be the Review Panel member. Each Safeguarding Adult Review needs consistent input and engagement from the agencies involved in order to ensure and efficient and high-quality end product. This needs to be considered when selecting the panel member. The Safeguarding Adult Review Sub-Group and Independent Reviewer should make recommendations as to who should form the Review Panel. The Review Panel should consist of representatives from the Buckinghamshire Council Adult Social Care, Health and the police and other representatives as appropriate to the individual case. They should also start to look at the Terms of Reference for the panel which will help to inform who should be part of the panel. There should be at least three people on the panel excluding the Chair.

12.3 As part of the process of information gathering each agency may want to undertake a separate Management Review of its involvement with the vulnerable adult (see below). This should begin as soon as a decision is taken to proceed with a Review, and sooner if a case gives rise to concerns within the individual organisation.

12.4 Where a court of protection contributes to the Review, prior agreement of the court should be sought so that those bound by a duty of confidentiality under court rules are able to contribute.

**13. Process for Conducting a Safeguarding Adult Review**

The following process is proposed following the decision to commission a Review being ratified by the Safeguarding Adults Board Chair:

13.1 Set up Meeting;-

A Review Panel should be convened. The first task is of the panel is to agree:

* Terms of Reference already outlined by Safeguarding Adult Review Sub-Group
* What information is required from each agency or person, stating whether this is through investigation or collected in other ways
* How and whether the vulnerable adult, family, carer or significant others are to contribute
* Support and other resources needed
* Timescales for reports to the Chair of the Panel and completion of the Review
* Dates, times and places of meetings
* Any legal advice required, in particular:
* Data Protection
* Freedom of Information Act
* Human Rights Act
* Mental Capacity Act.

13.2 Subsequent Meetings: A number of subsequent and sequential meetings will take place dependent on the complexity and nature of the Review. Where possible the dates for these meetings should be set in advance. Panel members should make every effort to prioritise these meetings to ensure consistent engagement and the production of a quality end product.

13.3 Information gathering. This may include;-

* Production of chronologies
* Individual Management Reviews (if used)
* Interviews with staff and family
* Practitioner events

13.4 Production of overview report: This should include all action plans from Individual Management Reviews plus any further actions from the Independent Reviewer. Action plans should be explicit as to;-

* Actions, expected outcomes and who is responsible
* Time-scales for completion

13.5 Sign off by Review Panel**:** Review the findings against the agreed Terms of Reference or requirements. The Panel Chair should ask the Review Panel to sign off the Safeguarding Adult Review.

13.6 **Each completed SAR report will come with a set of recommendations as proposed by the author of the report. It is the role and responsibility of the Panel to ensure that these recommendations are converted into an Action Plan that supports the delivery and ensures the impact of the recommendations.**

13.7 Every completed SAR report and action plan, once agreed and signed off by the Panel, will need to be viewed and agreed by the Safeguarding Adult Sub-Group. The Sub-Group will then formally sign off both documents before sending them to the Safeguarding Adults Board for approval.

13.8 Presentation to Safeguarding Adults Board: The Safeguarding Adults Board should agree what action is to be taken from the findings and

* Make sure that the overview report includes an executive summary and decide if both are going to be made public
* Agree an action plan from the recommendations in the overview report, to be included in the board’s overall work plan.
* Include the findings from any Safeguarding Adult Review in its Annual Report together with what actions it has taken/intends to take in relation to those findings.
* Programme for lessons learnt.
* 13.9 Following presentation of the SAR to the Board, and approval of the report by the Board, Buckinghamshire Safeguarding Adults Board willDevelop a Media statement
* Notify agencies involved in process of intent to publish with a copy of media statement and all documents (secure/draft)
* Notify families of intent to publish
* Document published on website

Some SARs will require a more formal publication process and the level of publication process required will be confirmed by the SAR Sub-Group.

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| **Revision History** | **Version** | **Changes made** | **Author** |
| **03/12/2010** | **2** | **Actions: considered fit for purpose and flow charts appendix C, D and E added.** | **SCR Business Sub-Group** |
| **August 2014** | **3** | **Reviewed August 2014 supporting paperwork developed** | **Safeguarding Adults Review BC** |
| **12/01/2017** | **4** |  | **SAR Sub-Group.** |
| **May 2017** | **5** | **Amendments: to ensure anonymising of forms is clear.** | **Nicky Barry** |
| **December 2020** | **6** | **Change of BSAB log and updates to sections 7/8/10 &13 to reflect new working practices** | **Vince Grey Safeguarding partnership Manager** |
| **October 2022** | **7** | **Grammar and formatting.**  **10.1, 13.1, 13.9 to reflect new working practices.**  **4.8, 4.9 to reflect change from SCR to LCSPR** | **Ashleigh Coneron**  **Safeguarding Practice Review Officer**  **BSAB** |