North Yorkshire Safeguarding Adults Board

Safeguarding Adults Review Policy

May 2016

Document information

North Yorkshire Safeguarding Adults Board (NYSAB)	Colin Morris Independent Chair of NYSAB
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Related documents	Care Act 2014 Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews, April 2011

Foreword

This document provides guidance on the North Yorkshire Safeguarding Adults Board (NYSAB) Safeguarding Adult Review (SAR) Framework. It is designed to assist people to decide when to refer a case for consideration as a SAR, as well as providing guidance on the SAR process itself.

Safeguarding Adult Reviews are undertaken for the purpose of understanding and learning from individual cases to continuously improve the effectiveness of the wider system. They are reserved for situations where there is potential for extensive systemic learning due to serious questions about the multi-agency system as a whole. SARs are commissioned and managed by the NYSAB and are only undertaken in circumstances involving the death or serious injury of a vulnerable adult or adults known to numerous agencies when it is believed that the death was caused by abuse or neglect, or that abuse or neglect contributed to the death or serious injury.

Contents

1. Introduction

Section 44 of the Care Act 2014 and associated statutory guidance[1] require North Yorkshire Safeguarding Adults Board (NYSAB) to conduct Safeguarding Adults Reviews (SARs) in certain circumstances, and permits the NYSAB to arrange SARs in other circumstances. The Act requires NYSAB member agencies to cooperate with and contribute to the carrying out of a SAR.

SABs need locally agreed processes for commissioning and learning from SARs. No single review model will be applicable for all cases: review methodology should be determined by the circumstances of each case.

"The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm." [2]

The policy sets out:

- the criteria for when NYSAB must or may commission a SAR;
- the processes for requesting and commissioning a SAR in North Yorkshire;
- a menu of options for conducting SARs in North Yorkshire;
- how adults, families and staff will be supported and involved in SARs; and
- how learning from North Yorkshire SARs and from other SARs nationally will be acted on in North Yorkshire;

It is anticipated that, in complementing national and regional guidance, the SAR policy will:

- ensure local processes comply with legal requirements and best practice;
- enable a consistent approach to SAR decision-making and practice;
- guide the NYSAB and local agencies involved; and
- set out transparently how effective SARs serve the public interest.

[1] DH Care and Support Statutory Guidance February 2016

[2] DH Care and Support Statutory Guidance paragraph 14.164.

2. Guiding Principles

The SAR process outlined in this document is underpinned by the following principles:

- the Care Act 2014 provides a statutory basis for undertaking the learning and review processes described;

- it is recognised that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and it is important to manage the interface between these;

- the SAR should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted;

- adults and their families must always be offered the opportunity to contribute to the review process and receive feedback on the learning outcomes achieved;

- all agencies involved in the case should be fully engaged in the SAR process and have the opportunity to contribute their views:

- the central focus of the SAR will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working;

- the SAR process should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew, or could have reasonably have been expected to have known, at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time;

- a SAR is not a disciplinary process and should be conducted in a manner which facilitates learning and allows for reflection; and

- where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a SAR.

3. Purpose of a Safeguarding Adult Review

The purpose of conducting a SAR 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 safeguard adults at risk.

The SAR 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 SAR is to:

- determine what might have done differently to prevent the harm or death;
- establish whether there are lessons to be learnt about the way in which local professionals and agencies work together to safeguard adults and apply these to future cases to prevent similar harm again;
- review the effectiveness of safeguarding arrangements and procedures (both multi-agency and those of individual organisations);
- inform and improve future practice and partnership working;
- improve practice by acting on learning (developing best practice);
- highlight any good practice identified; and
- prepare and commission an Overview Report (depending upon the methodology chosen to support the review process) which brings together and analyses the findings of the various Single-Agency Reports from agencies in order to make recommendations for future action.

The focus of a SAR should be upon the way in which local professionals and agencies work together to safeguard and promote the welfare of vulnerable adults and on the outcome of the process, the recommendations/actions and the monitoring and reviewing of the recommendations/actions. It will ensure that all appropriate actions have been taken, with a view to learning lessons for the future both locally and nationally, and that the learning is shared with appropriate partner agencies.

It is acknowledged that individual agencies may have their own internal/statutory review procedures to investigate serious incidents. This framework is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice. In order to conform to the objectives set for the NYSAB, there is an expectation that member agencies will support the SAR process as set out in this framework. Also that, agencies will have in-house systems in place, which will identify cases which will meet the criteria for a SAR.

Its purpose is not to reinvestigate or 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council. SARs are not part of any disciplinary process but information that emerges in the course of a SAR may indicate that disciplinary action should be taken under established procedures in the agency concerned. Alternatively, disciplinary action may be conducted concurrently and in some situations disciplinary action may need to be taken urgently to safeguard others. This will be a matter for the individual agency concerned.

Safeguarding Adults practice or procedural changes may be identified as being necessary at any point in the SAR process and may be made immediately if identified as urgent in order to safeguard others.

4. Criteria for SARs in North Yorkshire

The Safeguarding Adults Board is the only body that can commission a safeguarding adult Review. The NYSAB must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if:

there is reasonable cause for concern about how the NYSAB, member agencies or persons with relevant functions worked together to safeguard an adult with care and support needs (regardless of whether the local authority was meeting any of those needs) who:

- has died (including suicide), and the NYSAB knows or suspects that the death resulted from abuse or neglect (regardless of whether or not the abuse or neglect had been reported); OR

- is still alive, and the SAPB knows or suspects that the adult has experienced serious abuse or neglect.

"Serious abuse or neglect" may include:

- the individual would have been likely to have died but for an intervention,
- the individual suffered permanent harm as a result of abuse or neglect,
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect;3
- the individual has sustained a potentially life threatening injury through abuse or neglect,
- the individual has suffered serious sexual abuse.

This is not an exhaustive list. The final decision rests with the NYSAB as to whether abuse/ neglect was serious enough to warrant a SAR.

There is no requirement for a case to have gone through a Section 42 safeguarding adults enquiry before it can be considered for a SAR.

A SAR **may** be arranged by NYSAB for any other case involving an adult in its area with needs for care and support. A non-statutory SAR should only be commissioned when it is clear that there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future.

Appropriate cases for a non-statutory SAR may include:

- Serious incidents that do not meet the criteria for a statutory SAR but that NYSAB wants to review
- A case featuring repetitive or new concerns or issues which NYSAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

5. Liaison with HM Coroners

Where a death of a vulnerable adult occurs, and either abuse or wilful neglect are known or suspected to be a contributory factor in the death, the following action must be taken by the NYSAB (before a SCR is commissioned):

- The police representative on the NYSAB will contact the Coroner to identify whether an inquest will be or has been held. If an inquest is to be held, the timescales for this will be established and this will be reported to the Independent Chair of NYSAB.
- If an inquest is to be held, the Independent Chair of the NYSAB will notify in writing the Coroner in whose area the death occurred that a SAR under this policy is being undertaken.
- The Independent Chair of NYSAB will forward to the Coroner any terms of reference for the SAR that have been developed, and invite any comments from the Coroner, to avoid any conflicts between the two separate processes.
- If a conflict is identified, a meeting may be held between the Coroner and the Independent Chair of NYSAB to resolve any issues.
- Legal services should be consulted and copied into dialogue with the Coroner, and legal advice taken as to the timing if there are still court proceedings going on.

6. Making a Referral for a Safeguarding Adults Review

Any agency can use the process outlined below to request a SAR on a case believed to fit the criteria listed in section 4.

Where a professional or volunteer working for an agency is requesting a SAR, the request should first go through their organisation's appropriate management structure. The organisation's relevant senior manager and/ or representative on the NYSAB will then make the SAR request to the NYSAB. To ensure the efficient identification of appropriate cases for SAR consideration, relevant operational managers in agencies need to be aware of the criteria for a SAR.

If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. There may also be parallel processes in place such as a criminal investigation or coroner's inquest, which whilst not preventing a referral being made, will need to be taken account of in terms of the timing and management of any subsequent multi agency review.

Key questions to consider as part of internal processes include:

- Was the incident reported internally?
- Has an internal investigation been carried out?
- Has the investigation highlighted concerns about any other organisations?
- Has information come to light indicating abuse or neglect as a contributory factor?
- Based on findings, are criteria for making a referral met?

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 systemic 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 view about the referral and to discuss how they might want to be involved.

Requests for a SAR must be made in writing using the SAR request form (see Appendix 1), which should be completed as fully as possible. The request must be sent to the chair of NYSAB, by either secure email or post to protect personal and/or sensitive information. The NYSAB Business Unit will log the SAR request, notify the relevant statutory Director(s), and ensure all relevant information has been provided.

7. Making Decisions on SAR Referrals

On receiving a request, the chair of NYSAB will convene a SAR Sub-Group of three SAB members not involved with the case to decide whether the criteria for a SAR have been met (see section 4) and, if required, to decide which SAR methodology should be used (see section 9).

Each referral will be considered by the SAR Sub-Group. Involved agencies may be contacted by HSAB Business Unit to request completion of a scoping chronology to inform decision making about next steps. The Board Chair is ultimately responsible for the deciding whether or not to commission a safeguarding adult review, advised by the recommendation of the SAR Sub-Group.

A safeguarding adult review is a statutory process for cases meeting specific criteria.
For cases not meeting these criteria, the SAR Sub-Group may consider arranging another type of review. In cases other than those involving a statutory obligation, the sub-group should carefully consider whether commissioning a non-statutory SAR would be a valuable exercise: i.e. whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focussed on those cases that will yield the greatest learning and practice development.

Considering the following questions may help to establish whether there are sufficient lessons to be learned and value in commissioning a non-statutory SAR:

- Was there a “near miss”?
- Does the case indicate that there may be failings in how our adult safeguarding multi-agency policies and procedures function, leading to serious concerns about how professionals/ services work together?
- Did the system not recognise/ share evidence of risk of significant harm to an adult (or recognise/ share it late)? Is there evidence that system conditions lead to poor multi-agency working or communication?
- Does that case involve serious or systemic organisational abuse and multiple alleged perpetrators, from which learning could be transferred to other organisations to prevent such abuse or neglect in the future?
- Could the case potentially yield systems learning around how agencies work together to prevent and reduce abuse and neglect that would help us do things different in the future?
- Would a SAR on the case enable the NYSAB to be proactive and pre-emptively tackle practice areas or issues before harm arises?
- Does intelligence from other quality assurance and feedback sources (e.g. audits/ complaints) suggest that the kind of issue in this case is new/ complex/ repetitive and conducting a SAR would therefore be beneficial?

- Has this happened before (in North Yorkshire or elsewhere) and was a SAR commissioned then? Has the learning from any previous SARs been implemented or is there new learning to be identified?

- Is there adverse media interest or serious public concern?

- Is there evidence of sufficient good practice that could be mainstreamed across the partnership to the benefit of adults and their families?

The Sub-Group should also consider whether another review or learning process has already been commenced that will identify and share lessons to be learned, or which NYSAB could potentially feed into to avoid duplication (e.g. Domestic Homicide Review or health Serious Incident process).

In making a decision to commission a SAR the NYSAB Chair and panel of Board members should aim for consensus, not a majority view. If the Sub-Group cannot come to a consensus, the final decision will rest with the Chair of NYSAB after carefully considering the views of all panel members.

The Chair of NYSAB will write to the requestor and relevant statutory director(s) to inform them of the outcome of the SAR request and reasons for the decision. The chair will notify the NYSAB Business Unit who will update the SAR log, and inform The Safeguarding Adults' Board of the decision, brief circumstances and scope of a Review.

If a request for a SAR is upheld, the SAR Sub-Group will commission this on behalf of the NYSAB, having considered the most appropriate methodology to use, either the traditional method or the systems learning approach. Depending on the circumstances the group may also consider using a model which incorporates elements of both models as a 'hybrid' model. The Chair of NYSAB will:

- write to the chief executives (or equivalent) of all relevant agencies (copied to their respective Board member) to notify them of the decision to commission a SAR and the methodology to be used. Chief executives (or equivalent) must make the necessary arrangements for participation in the SAR, e.g. securing files and records, nominating a representative for a SAR panel etc.
- arrange for relevant commissioning and regulatory bodies to be notified that a SAR has been initiated.

If a request for a SAR is turned down, and where the requestor is dissatisfied with this outcome, they should notify the Chair of NYSAB in writing, who will discuss and review (if necessary) the decision with the requestor and the panel of Board members who decided on the initial request.

If a decision not to hold a SAR is upheld, the requesting agency can choose to take no further action or to undertake an internal review using an appropriate methodology. All relevant organisations must continue to implement any actions in the protection plan from any original Section 42 safeguarding enquiry.

8. Interface with other proceedings or investigations

Some cases referred may overlap with other statutory review processes such as a Domestic Homicide Review, Mental Health Homicide Review (DHR), MAPPA review or a Children's Serious Case Review (SCR). In these circumstances, the Board Mangers and Chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

Where such reviews may be relevant to SAR (e.g. because they concern the same perpetrator), consideration should be given as to the most appropriate and effective review methodology to achieve joint outcomes, enabling organisations and professionals to learn from the case, and avoid duplications of process, this may include:

- a jointly commissioned review; or
- parallel reviews; or
- a single review commissioned by only one agency – with a decision made as to who will be the lead agency for this

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a Children's Serious Case Review (SCR) and a Domestic Homicide Review (DHR).

When running a SAR and DHR or child SCR all relevant areas that need to be addressed should be established at the outset to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the Independent Chair of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

There may be a criminal investigation running concurrently with the safeguarding adult review. In these situations, the criminal investigation takes precedence, although this should not delay the work being undertaken in respect of the safeguarding adult review. Any possible witnesses should be interviewed first by the police as part of any criminal proceedings before being interviewed for the purposes of their agency's individual management review (IMR). It may also be necessary to delay the publishing of overview reports until the conclusion of any criminal trial. Single agencies can however progress with implementing the learning from individual IMRs.

It is also acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents. This policy is not intended to duplicate or replace these and any opportunities to prevent duplication will be encouraged. In some cases, dependent on the specific issues in the case, internal investigation reports may provide adequate information to address the terms of reference or it may be that additional reports are required to address any outstanding areas. Careful planning and communication is required to make the most effective use of resources and avoid duplication. It may be necessary for the SAB to request information and/or reports arising from other statutory reviews to inform the safeguarding adult review process. Any such requests will be made under section 45 of the Care Act 2014.

Safeguarding adult reviews are not part of any disciplinary process. However, should information emerge in the course of the safeguarding adult review that may indicate that disciplinary action should be taken the agencies concerned should deal with such issues in accordance with their own procedures. If disciplinary matters are in progress at the commencement of the safeguarding adult review these should be notified to the NYSAB Business Unit.

9. Making a decision on SAR Methodology

SARs can be conducted in a variety of ways, and no single model is prescribed. The choice of approach for each SAR is significant, as how a review is conducted will influence the learning and whether the process is constructive and educative for those involved (SCIE 2015).

Traditional methods involve analysis of the involvement of agencies through independent reviewers and an independent panel involving two key stages. Individual agencies are asked to review the practice within their organisations the collated findings of which then form part of an overview report usually written by an independent author. Other examples (not exhaustive) of learning models which may be considered are:

The SCIE learning together model
The Learning Together approach has been used in both safeguarding adults and safeguarding children's reviews. The model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture. Practitioners are part of the case review team, their perspectives are used to inform all aspects of the Review, including lessons learned.

SILP (Significant Incident Learning Process)
This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

Root Cause Analysis (RCA)
RCA has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

Appreciative Inquiry (AI)
This approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change. SARs conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements.

The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

SAR chair – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience:

- Strong leadership and ability to motivate others
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
- Good analytical skills using qualitative data
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge

- Commitment to/ promotion of open and reflective learning cultures.4

SAR Panel – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review, but should comprise a minimum of three members in addition to a chair with a level of independence from the case under review.

Terms of reference – published and openly available.

Early discussions with the adult and their family, carers and friends – to agree to what extent and how they would like to be involved in the SAR, and to manage expectations. This includes access to independent advocacy if required (see sections 11 & 12).

Appropriate involvement of professionals and organisations who were working with the adult – to contribute their perspectives without fear of being blamed for actions they took in good faith (see section 13).

SAR report and recommendations – see section 15.

The following should be considered in selecting a SAR methodology:

- Is the case complex, involving multiple abuse types and/ or victims?
- Is significant public interest in the review anticipated?
- Is large-scale staff/ family involvement wanted/ appropriate?
- Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained lead reviewers available in-house or nationally for the method selected? Are resources available to train or commission a lead reviewer?
- Can value for money be demonstrated?

Each methodology is valid in itself and no approach should be seen as more serious or holding more importance or value than another. The methodology selected must offer the most effective learning and involvement of key staff/ family weighed against the cost, resources and length of time required to conduct the review. The Chair of NYSAB and SAR Sub-group should use its collective experience and knowledge to recommend the most appropriate learning method for the case (including hybrid approaches).

In selecting a SAR methodology the NYSAB Chair and SAR Sub-group should aim for consensus, not a majority view. If the Sub-group cannot come to a consensus, the final decision will rest with the Chair of NYSAB after carefully considering the views of all panel members.

Once a methodology has been selected, all SAR panel members and others participating in a SAR will be fully briefed on the methodology to support them in carrying out their role. SAR panel chairs must not be too rigid or constrained by the methodology chosen – chairs may allow a degree of flexibility within each methodology, allowing SAR panel members to do things slightly differently where appropriate, in order to secure the maximum learning and benefit from the review.

In addition to selecting a SAR methodology, the Chair of NYSAB and the Sub-Group must also decide:

- Which agencies (including legal, communications and CQC as required) should be asked to participate in the SAR panel.
- Level of independence from the case required of panel members (it is advisable that panel members have not had involvement in the case nor line management responsibility for staff writing a report for the SAR).
- Whether agencies are required to secure their files/ records.
- Level of independence required of the SAR chair (e.g. representative from another agency, external consultant etc.)
- The Terms of Reference for the SAR, including timescales for completion and how learning from the SAR will be disseminated and embedded
- The required output from the SAR (e.g. a report).

Regardless of the methodology selected, all SARs should be completed within six months unless there are extenuating circumstances (e.g. potential to jeopardise police or court proceedings). SAR panel members should try to agree an appropriate timescale for the Review at the outset.

10. The Safeguarding Adults Review Process

The SAR will be undertaken in accordance with the guiding principles outlined on page 6.
The Chair of NYSAB will invite the preferred candidate to chair the SAR panel, and brief them on the agreed methodology. A multi-agency Safeguarding Adult Review Panel will be set up within one month, with membership comprised of appropriate representatives of the agencies involved.

The chair of the SAR Panel is responsible for:

- establishing individual terms of reference and setting timescales for the SAR in agreement with the Safeguarding Adults Board.
- setting SAR panel meeting dates and agendas as required;
- inviting all nominated representatives from relevant agencies to SAR panel meetings;
- ensuring the review is conducted according to the terms of reference and methodology;
- notifying NYSAB of any administrative/ resourcing arrangements that are missing;
- on-going liaison with the police and/ or coroner's office as required;
- arranging early discussions with the adult(s) and their family/ representatives, and requesting the arrangement of any support they require to participate;
- initiating the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice; and
- requesting any data/ evidence/ reports from partner agencies as required.

Responsibility for the management of safeguarding adult reviews is delegated to the Quality and Performance Sub-group. This group is responsible for establishing an independently chaired safeguarding adult review panel to undertake the review and will maintain an oversight and co-ordination role throughout the process. The Quality and Performance Sub-group is also responsible for ensuring the smooth running of the process, ensuring timely completion of reviews and for keeping the Board updated.

If the Board requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the Board in accordance with section 45 of the Care Act 2014. The Chair of NYSAB will write to the Chief Officers of all the agencies involved for nominations to the SAR panel, and will request that records relating to the subject(s) of the SAR are made secure to prevent any adaptation

The SAR will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. The core skills and experience expected of reviewers 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 analytic skills and experience of collaborative problem solving;
- ability to manage potentially sensitive and complex group dynamics;

- excellent interpersonal skills; and
- safeguarding experience and understanding of vulnerability and its impact.

The SARs must be completed in a timely manner. Once the decision to commission a review has been made, the review process should be completed within six months unless otherwise agreed by the Board Chair. 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 SAR relates to serious organisational abuse, or where multiple perpetrators are involved, such reviews are likely to be more complex and may require more time.

11. Independent Advocacy

Under section 68 of the Care Act 2014, 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 s67 Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, 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 and support them. It will be the responsibility of the local authority to arrange and fund advocacy support in these circumstances.

12. Involving the person, their family, or carers

Adults and/or families/carers should be invited and supported to contribute to SARs if they wish to do so, in order that an inclusive approach is taken and that their wishes, feelings and needs are placed at the heart of the review. From the outset consideration should be given to the breadth and depth of involvement of the person their family and or carers throughout the review process which should adhere to the following principles:

- Negotiation (that includes family input in determining the terms of reference for the review);
- Transparency in limits and opportunities (agreement is needed about the level and reach of participation);
- Inclusivity;
- Sensitivity (boards and review leads need to exercise considerable professional judgment in the methods and approaches adopted to facilitate participation);
- Evaluation (seeking feedback from family members on the process of any review will enable learning to be developed about family involvement).

The SAR Panel chair must attempt to make contact with the adult(s), their family and/or representatives early on (ideally before the first SAR panel meeting) to establish:

- why and how a SAR will be undertaken into their (family member's) case.
- how they would like to be involved – e.g. views contributed via telephone conversation, or interview, or attendance at SAR meetings.
- any support or adjustments they would need to facilitate their involvement.
- their initial views, wishes, concerns, and any answers/ outcomes they would like to achieve from the SAR.

Reasonable and appropriate support and adjustments should be made by NYSAB as required to enable the adult(s), their family and/ or representatives to participate in the SAR. This may include, but is not limited to:

- easy read, large print and/ or translated materials;
- access to an interpreter;
- support from a chosen chaperone or representative;
- longer meeting times;
- pre-meeting briefings and post-meeting de-briefs; and
- access to a statutory independent advocate.

Where relevant, the SAR Panel should nominate and agree individuals to link to the family with police family liaison officers and other involved professionals to ensure family members are clear about the role of the SAR.

Where an interview is offered, the SAR Panel meeting will decide how the interview will be conducted and by whom, in line with Terms of Reference. Where face to face interviews are undertaken this will always be by two agreed professionals. This is to ensure accurate evidence is gathered and all key issues are covered in what can be a highly emotionally charged meeting.

Transcripts of the interview will be written and added to the SAR file held by NYSAB. The SAR Panel will be responsible for deciding how the information provided is presented in the Overview Report and Executive Summary.

The SAR Panel will agree initials to be used to represent the subject of the SAR and family members. These will not be the family name initials and no family members' names will be used in the reports in order to ensure confidentiality. The family may be asked to suggest a name to adopt.

Where individuals/family members/carers have refused to be part of the SAR this will be clearly recorded within the Overview Report, although every effort will be made to facilitate their involvement in the process. It is essential that if the family members decline at the initial stage to be involved arrangements are made to update them and opportunities provided to be involved at a later stage. It will be the responsibility of the nominated links to the family (agreed in the Terms of Reference) to update family members of the progress of the SCR. At the conclusion of the SAR, a nominated person from the SAR Panel will offer a meeting to those individuals who have contributed. A copy of the Executive Summary will be provided, unless the NYSAB decides this is not in the best interest of the subject of the SAR – decisions will be made on a case-by-case basis.

Any disputes and complaints will be managed by the Independent Chair of the SAB

13. Responsibilities to staff

Agencies are responsible for ensuring staff are provided with, and given access to, emotional support. This support should be clearly identified and communicated to all staff involved. The death or serious injury of a vulnerable adult will have an impact on staff and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff involved to the team, organisation or workplace.

The SAR process itself provokes worry in many professionals. However, the purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff. However, on occasion concerns about an individual's practice may be raised through the review process and these concerns would be fed back to their agency through the SAR Panel Chair. Any action, including disciplinary action as a result of this, would remain the responsibility of the individual agency.

As soon as a SAR has been agreed, staff who have had involvement should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff and their line managers. It should be made clear that the SAR process can be lengthy.

Information should be provided about sources of independent support staff may wish to use in connection with their involvement in the review, e.g. organisations' staff support schemes, Human Resources, Occupational Health, workplace well-being schemes, Trade Unions or professional bodies etc.

It is important that all relevant members of agencies are interviewed and given an opportunity to share their views on the case. It would, in most cases, be appropriate to interview the staff member and manager for the case separately.

Staff members providing information and attending interviews about their role and actions in relation to the case should, wherever possible, be given at least two weeks' notice of the interview, and invited to be accompanied by someone of their choice (with prior consent by the employer). Staff members should be allowed to view the relevant paperwork to aid their recall.

The interview process is designed to gather information not only about the individual's practice, but their views on the multi-agency and organisational practice at the time. Professionals should be asked their views about what, in their opinion, could have made a difference for the adult or family.

Agencies need to ensure staff feel the process is transparent and staff involved feel their views have been represented. Therefore it is appropriate to share the record of the interview with the staff member.

After the Overview Report has been issued the Panel Member should extract the sections of the report that directly concern individual staff and invite staff to read these extracts in conjunction with the Executive Summary and discuss them with an appropriate line manager. In order to ensure confidentiality, staff will not be permitted to retain these extracts, until after publication.

A line manager will subsequently be required to discuss with the staff involved the implications for them of the review. This may include actions such as additional training but should also consider if the staff member requires any further emotional support.

All staff will be briefed prior to the publication of the reports by their agency representative on the SAR Panel.

I4. Disclosure of Information and documents to interested parties external to the SAR

The SAR process is conducted in accordance with the Safeguarding Adult Review Protocol. It is established in guidance and case law that in order for there to be openness and candour within the SAR process to enable the purposes of the process to be achieved, it is necessary to protect confidentiality particularly in relation to related agency reports. This must be balanced with general principles of openness and transparency applicable to public process, and compliance with relevant legislation in relation to disclosure of information.

Decisions regarding disclosure of information to the family or other interested third parties may vary according to the timing of any requests and the stage reached within the SAR process.

Any agency producing documents for the SAR will be required to makes its own decision regarding disclosure to third parties who seek this.

Other than the final report, documentation will not be disclosed to the family or other individuals external to the SAR process prior to the completion of the Report.

The Final Report will be subject to redaction as required by the Data Protection Act 1998 and will be provided to the family and other external bodies as deemed appropriate following full consideration of all issues.

Any request for access to documents will be considered in accordance with the principles of the Freedom of Information Act 2000 and the Data Protection Act 1998. Decisions will be made by individual agencies in relation to requests for disclosure of their documents, including the reports for which they are authors.

Any request for information by the family or indeed any other external parties to the SAR, addressed to individual organisations participating with the SAR process, should be processed in accordance with the applicable legal framework, primarily the Freedom of Information Act 2000, Data Protection Act 1998 and the Human Rights Act 1998.

A range of exemptions under the legislation referred to above could potentially apply to the information requested. The fact that there may be grounds for withholding disclosure does not automatically mean that this will follow. Decisions about disclosure should be made with reference to the circumstances that apply at that time and may change over time as the SAR progresses and is ultimately concluded.

15. SAR Reports

The required output of a SAR – e.g. whether a report is needed, and/ or independent authorship – is to be set out in the SAR terms of reference. It is anticipated that in all statutory SARs and some non-statutory SARs a short report will be required.

The SAR panel chair must ensure that there is sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR panel should form the basis of any SAR report, to be produced by the nominated author.

The SAR panel should receive and agree the draft report before it is presented to NYSAB so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented.

The adult(s) and/ or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process.

NYSAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This should include publication via the NYSAB webpages, but could also include dissemination via the Knowledge Hub and/ or regional networks. Considerations of reputational risk or national learning arising from the case may affect decisions to publish. Any reports to be published must be fully anonymised.

The chair of NYSAB will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with North Yorkshire's information sharing agreement, the Data Protection Act and other legal requirements.

Acting on the Recommendations of the SAR

NYSAB will translate learning from the SAR report into recommendations and a proposed multi-agency action plan if required, which should be endorsed at senior level by each organisation to whom it relates.

The multi-agency action plan will indicate:

- the actions that are needed.
- responsibilities for specific actions.
- timescales for completion of actions.
- the intended outcomes: what will change as a result?
- mechanisms for monitoring and reviewing intended improvements.
- the processes for dissemination of the SAR report or its key findings.

Individual agencies may also be asked by the NYSAB to produce their own internal action plans if required.

Board members of NYSAB are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is

embedded in their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.

NYSAB will monitor progress on all recommendations (or delegate to an appropriate sub-group) and may request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

In line with Schedule 2 of the Care Act, NYSAB will include findings from any SARs in its annual report, and information on any ongoing SARs. The annual report will list for completed SARs what action was taken or is intended to be taken in relation to the findings, or where NYSAB decided not to implement a recommendation the reasons for that decision.

16. Supporting and Resourcing SARs

Section 44(5) of the Care Act requires each member of NYSAB to co-operate in and contribute to the carrying out of a SAR, with a view to:

- identifying the lessons to be learnt from the adult's case; and
- applying those lessons to future cases.

Partners are required under Sections 6 and 7 of the Care Act to:

- co-operate in general in the performing of statutory functions under the Care Act that relate to protecting adults with needs for care and support and/ or carers from abuse and promoting their wellbeing, including SARs.

- co-operate when requested in relating to specific cases, such as SARs.

In addition, Section 45 of the Care Act places a duty on all partner organisations to supply information to NYSAB (or other specified person) where they are likely to have relevant information that will enable or assist the SAB in exercising its functions – including conducting SARs.

Resources are needed for undertaking and supporting a SAR. The statutory partners on the NYSAB will provide resources, in cash or kind, on a shared basis to ensure that the relevant costs for each SAR can be met. These will vary according to the methodology selected – e.g. a SAR requiring the services of consultants as independent chair and independent author will be more costly.

The statutory partners on the NYSAB will also ensure that the SAR chair and panel receive adequate administrative support, and will take a decision on how and from whom this will be provided.

All partners will commit internal resources to the production of evidence for a SAR (e.g. an IMR or interviews/ conversations with relevant staff) as requested by the SAR panel.

The Head of Engagement and Governance will maintain an annual overview of SAR related costs for the SAPB, for consideration each year as part of the annual report and to aid annual budgeting by partner organisations.

17. Media, Communication and Publication

As North Yorkshire Heath and Adult Services are the lead agency for adult safeguarding, media and communication issues will be co-ordinated by the North Yorkshire County Council's Communications Unit on behalf of the Board and in collaboration with the communications teams of the other agencies involved.

North Yorkshire County Council's Communications Unit will be briefed as soon as a decision has been made to undertake a SCR and will be kept up to date with the progress of the review by the SAR Panel Chair or nominated officer. They will advise as to whether press releases are required during the course of the review as a result of media interest resulting from any police or court action. North Yorkshire County Council's Communications Unit will keep other agencies' press officers informed as required.

If any other agency receives press enquiries these should be directed to North Yorkshire County Council's Communications Manager.

A media strategy meeting will be held prior to the SAR being published, and a copy of the media strategy communicated to all organisations involved in the SAR and copied to relevant elected Members.

Publication of the SAR will be managed through publication on the NYSAB Website. At the point of publication the Board Chair will release a statement outlining the reasons for the key findings and required actions. It has been agreed that the norm will be to publish a full anonymised report unless there are exceptional circumstances not to do so.

North Yorkshire Safeguarding Adults Board

Safeguarding Adults Review Request Form

North Yorkshire SAB considers every SAR request on the basis of whether it meets the criteria for a Safeguarding Adults Review (see section 4 of the North Yorkshire SAR Policy).

The Board needs as much information as possible to enable members to make a proportionate decision as to how to respond to a SAR request, ensuring, if the case is accepted for a review, that maximum learning can be achieved. Please therefore complete as much information on this form as possible.

If you have any questions, please do not hesitate to contact the SAB Business Unit on nysab@northyorks.gov.uk

Submit your form by post to:

Independent Chair
North Yorkshire Safeguarding Adults Board
c/o Health and Adult Services
North Yorkshire County Council
County Hall
Northallerton
DL7 8DD

Or submit by email to nysab@northyorks.gov.uk

Details of individual/organisation requesting the SAR

Name	
Position/designation	
Organisation	
Address	
Contact telephone	
Contact email	

Authorising manager	
Position/designation	
Contact telephone	
Contact email	

Date of request	

Details of adult at risk:

Name	
Address	
Date of birth	
Date of death (if applicable)	
Ethnicity	
GP (if known)	
Family/next of kin/advocate/representative	
Health and/or other presenting needs	

Details of person/organisation alleged responsible for harm:

Name	
Address	

Brief outline of the case/incident (with dates and locations if known)

Summary of why this case meets the criteria for a SAR (section 4 NYSAB SAR Policy)				
Do you believe a statutory SAR is required in response to this case?	**Yes**		**No**	

What learning do you think can be achieved through a review of this case?

Has any other learning/review process already been followed (eg internally?)	Yes		No	
If yes, please specify the review conducted, learning identified, how it was disseminated and impact				

List of individuals and their agencies/service providers known to be involved in the case

Any other relevant information that will help NYSAB decide whether a SAR is required