**East Riding of Yorkshire Safeguarding Adults Board**

**Procedure for completing Safeguarding Adults Reviews**


*Safeguarding is everybody's business*

Procedure to be followed by all partner agencies who may be asked to contribute to a safeguarding adults review (SAR) or Learning Lessons Review (LLR)



Final April 2018

**East Riding Safeguarding Adults Board Version Control Template.**

All documents produced by the East Riding Safeguarding Adults Board support function, whether electronic or hard copy will be uniquely identifiable. In many instances, it is necessary to track the changes that occur to a document throughout the document's development and subsequent revision(s). Version Control is the management of multiple revisions of documents via the use of a Document Control Sheet and Version Numbering incorporated into each document name.

The Version numbering system to be used by the East Riding Safeguarding Adults Board is the system that is based on the use of version numbers with points to reflect major and minor changes to a document.

The version number of a document in a draft format will start at 0.1 reflecting its draft status and then progress through revision by incrementing the number to the right of the point. The version number will convert to 01.0 upon the document/record receiving all required approvals, and deemed ready for publishing.

When the document has been approved and authorised ready for publishing the version number will start at 01.0, and the number will only be modified after the first minor amendment to become 01.1. A major revision to the document will result in the number to the left of the point incrementing by one and the number to the right of the dot point will return to zero e.g. 02.0.

**Revision History:**

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## 1. Introduction

1.1 The Safeguarding Adults Review Group (SARG) is a sub-committee of the East Riding Safeguarding Adults Board (SAB). The SARG is responsible for recommending whether a Safeguarding Adults Review (SAR) needs to take place and the type and style of SAR which will be best suited to the individual case. Some examples of the methodologies used to conduct a SAR are shown in **appendix 1.**

1.2 However, the best way to approach a SAR is to ensure it is proportionate to the case being reviewed and brings out the most in-depth learning by conducting the SAR. The "type" of review conducted becomes irrelevant as long as its ultimate aim is reached which is to learn from the case and share this learning as widely as possible, to improve standards and practice and to safeguard others.

1.3 Once the SAR has concluded, the SARG is responsible for assuring the SAB that all recommendations and actions which are identified in a SAR have been fully implemented by the appropriate partner agencies.

1.4 The SARG also has a role in reviewing cases which become of interest nationally due to their severity. This is to provide assurance that any national recommendations which may have an impact locally are also addressed by partner agencies.

1.5 This document sets out the criteria for conducting a SAR and provides some of the recognised options for conducting those reviews, along with the techniques to be used to ensure a thorough review is undertaken. The document also provides some governance of the process so that reviews are conducted as timely and effectively as possible.

## 2. When is a SAR arranged?

2.1 SABs arrange a SAR when an adult in its area 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.

2.2 SABs also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. Something may 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.

2.3 SABs are also free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

## 3. Legal Context

3.1 One of the three core duties of the SAB is to conduct a SAR in accordance with Section 44 of the Care Act.

3.2 The Care Act 2014 Section 44 states that a Safeguarding Adults Board (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-

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.

1 Condition 1 is met if-

a) the adult had died, and
b) 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).

2 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.

3 A SAB 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).

## 4. Levels of SARs

4.1 The SAB will utilise two levels of SAR.

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

## 5. Purpose of a SAR

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.

## 6. Principles

6.1 The following principles apply to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

- The individual (where able) and their 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 Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and that appropriate action is taken to secure improvements in practice.

- SARs should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

- Professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

- SAR's should be completed in a timely manner and within six months unless there is a reason for a longer period e.g. ongoing court proceeding.

- SARs should all result in the production of an output, be it a full report, action plan, set of recommendations or similar.

- The findings from any SAR will be published in the SAB Annual Report along with the actions taken in relation to those findings.

## 7. Making a referral for a SAR

7.1 Any agency can make a referral for a SAR if they identify a case where they believe that the criteria for a SAR are met (**see section 3**). Examples of how a case might be identified are:

- Information presented on an initial safeguarding concerns form, or through further information gathering.
- During an ongoing Safeguarding enquiry/S42 a practitioner may identify a case.
- An agency may identify a case that has not had a safeguarding enquiry e.g. police may identify that a case they have been investigating meets the criteria for a SAR.
- The coroner, MP's and Elected Members of East Riding Council may have a case brought to their attention where they feel a SAR referral is appropriate.
- Referrals can be made by family members, carers and members of the public.

## 8. Submitting a referral

8.1 Requests for a SAR must be made in writing using the referral form attached as **appendix 2** which should be completed as fully as possible and returned to East Riding Safeguarding Adults Board at the secure email sab@eastriding.gcsx.gov.uk

## 9. Escalation through internal management structures

9.1 Where a professional or volunteer working for an agency has identified a possible SAR referral, the case should first be considered internally within the organisation at the appropriate level. Each agency/organisation needs to decide how any SAR referral will be verified internally before the referral is made to the Safeguarding Adults Board. This process should be clearly communicated to staff and noted in any single agency safeguarding adults policy.

9.2 The completed form requesting a SAR be considered must be signed off by a senior manager prior to it being sent to the SAB.

## 10. SARG Decision-making process

10.1 Upon receipt of the request, the SARG will consider the referral at the next planned meeting. Alternatively, if the referral is deemed critical or severe enough to warrant an extra-ordinary meeting then the SAB support function will aim to arrange a meeting at short notice and agencies should try to prioritise this request.

10.2 If there is insufficient information on the request form to enable the SARG to make a decision some further information will be requested from the referrer. This will be via a discussion by a nominated SARG member with the individual who submitted the referral. This will be done in time for a decision to be made at the next planned SARG meeting.

10.3 When a decision is reached by the SARG that a SAR is to be conducted the relevant agencies involved in the case will be requested to provide more detailed information about their contacts with the adult under review. In the majority of cases this will be a **chronology** of contacts with the adult with some analysis. More details about this process are provided later within these procedures.

10.4 The chronology must be supported by some robust analysis such as any gaps in care/services identified, missed opportunities, areas of best practice etc. This will help the reviewers gain an appreciation of how and why aspects of care may have "gone wrong".

10.5 The people tasked with completing the chronology will form the Review Panel should a panel be required to move forward the review. This may not always be necessary. They should not have had any direct involvement with the adult at risk. More details about this process are provided later within these procedures.

The template chronology is embedded here

excel chronology.xlsx

## 11. The Chronology

11.1 To deliver good quality SARs the chronology needs to be more than a sequence of events by an individual agency then merged. It needs to act as a gauge to the overall quality of the service provided and whether this met or did not meet the required standards expected at the time.

11.2 Where deviation is identified, or suspected then there needs to be clarity at an early stage regarding the significance of the deviation. Is it "serious" or does it represent a reflective learning point, but does not meet the threshold of a serious lapse in practice or process.

**Key points when completing the above chronology**

- Use when there is an antecedent chronology (story-line) leading to the incident under investigation.
- Use the format and formulas already set up in the attached chronology as there may be a need to merge other chronologies in a sequential process.
- Patient and staff identities can be used in the initial chronologies however they will **never** be used in either a combined chronology or any reports thereafter.
- The chronology writer should aim to rigorously analyse the involvement of their agency. Consider the actions taken or not taken and comment upon them.
- Try to get an understanding of not only what happened but why it happened.
- Facts should not be stated without their origin.

11.3 Agency chronologies (or any alternative information requests at this first stage) must be returned within 10 working days to sab@eastriding.gcsx.gov.uk

11.4 Where there is more than one chronology the SAB support function will collate all chronologies into a combined multi-agency chronology for discussion and consideration about the way forward at the next scheduled SARG meeting (or an alternative panel meeting if one is being used). This discussion will include details the scale and depth of review to be held.

## 12. Recommendations for Action

12.1 After completing your chronology and analysing its contents, if there are any recommendations which you would wish to see in the final SAR overview report please complete the action plan template below. These can be actions for your own agency or suggestions for other agencies. Suggested actions for other agencies will have to be agreed with them prior to production of the final overview report. All suggested actions should be focussed and specific and capable of being implemented and may be divided into the following:

**Existing issues –** practice which should already be happening
**New issues –** actions that need to be introduced and implemented

12.2 In completing this please consider the following:

a) What changes (if any) could be made to the agency/organisation's Safeguarding Adults procedures?
b) What changes (if any) could be made in inter-agency working in the light of this case?
d) What areas of good practice are there? Could these be expanded?
d) What action should be taken by whom and by when?
e) What outcomes or changes should these actions bring about?
f) How will the agency/organisation review whether they have been achieved?
h) Is your suggested action affordable?


excel action plan.xlsx

**13. National recommendations**

12.1 There may times when either a single agency of the review panel conclude that a change can only be made by a national recommendation, as something requires implementing nationally for the change to then be effected locally. If this is the case then the national recommendation should be still noted in the report clearly noting that it is for national implementation. The review panel can then discuss and decide which national body needs approaching so that the recommendation does not get lost.

**Email completed recommendations to:** sab@eastriding.gcsx.gov.uk

**14. Further actions after receipt of agency chronologies and recommendations for action**

**14.1 Role of the SAB support function**

14.2 When the SAB receives the chronologies and recommendations for action these will be saved and all the information contained will be captured into one overall combined chronology along with a proposed action plan. The SAB board Manager will read all the information and may make suggestions for additional recommendations.

14.3 Where information is vague or further clarity is required in order to complete the combined chronology to a comprehensive standard the SAB support function will contact the relevant agencies direct to obtain this clarity.

**15. Actions to be taken upon receipt of the combined chronology**

15.1 At the next meeting of the SARG/SAR panel the group will review all the information being presented. This review will enable individual agencies to challenge each other around the decisions made and the actions taken which are described in the combined chronology.

15.2 The recommendations for action will also be discussed and agreement reached on whether to include all the suggested recommendations in a final report.

The SARG/SAR panel will decide on whether to:

- Complete the review at this as they feel there is no merit in undertaking a full SAR/Learning lessons review (LLR)
- Continue to undertake a full SAR/LLR.

## 16. Actions to be taken if the review concludes at the chronology stage

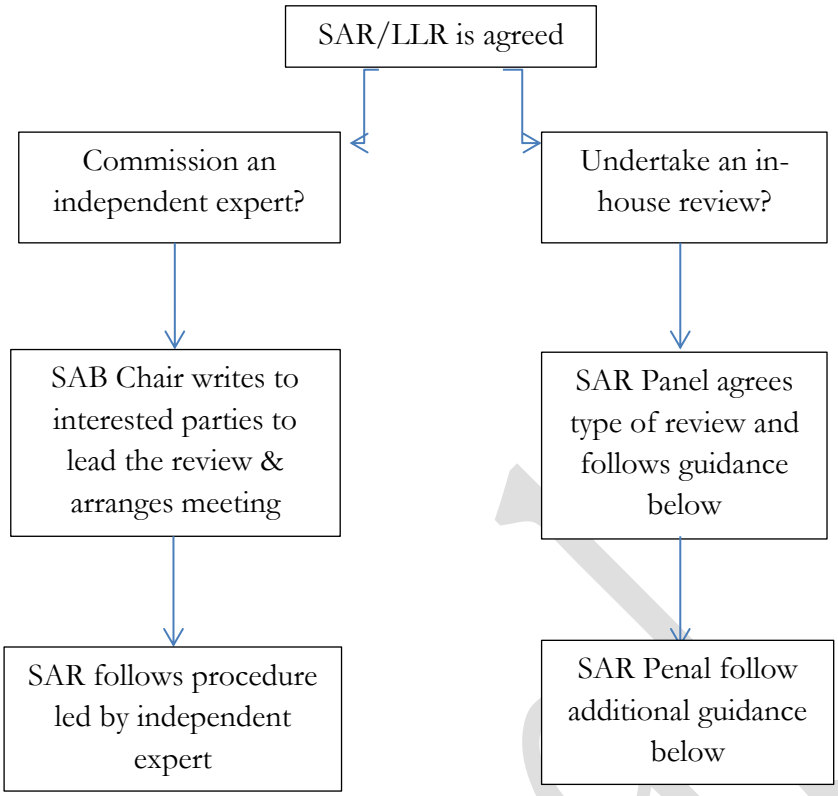
16.1 If it is decided further review is not necessary a final report will produced at this stage which includes the agreed recommendations/actions along with the rationale for not undertaking further review. The SAB Board Manager will prepare this report and circulate to all SAR participants for comment. Outstanding actions will be monitored by the SAB. **(See sections 32 & 33 on Final Report and action plan)**

## 17. Actions to follow if undertaking a full SAR/LLR

17.1 The following parts of these procedures offer guidance on how to undertake a SAR or LLR. The information obtained so far from the individual chronologies and the combined chronology will always be used as the starting point for any further type of review. If a SAR panel has been established this panel will be used to continue to progress with the next stages of the review. They should aim to meet at regular intervals so that the SAR will be **completed within the 6 months max timescale.**

## 18. Key steps in the SAR/LLR process

- ✓ SAR Chair to make the recommendation to the SAB Chair to progress with the review. It is the SAB Chair who makes the final decision.
- ✓ SAB support function to prepare letters to the CE/Director of all agencies who are required to be involved (template letter attached as **appendix 5**).
- ✓ SAB support function to prepare letter to the adult/family or advocate (template letter attached as **appendix 3**)
- ✓ SAR Panel to agree on aims of the review
- ✓ SAR Panel to agree Terms of reference of the review (see guidance on section 20)
- ✓ SAR Panel to agree whether this review is to be commissioned (using an expert reviewer) or managed in-house by SAB partner skills and experience.




## 19. SAB actions when a decision has been made to undertake a SAR

19.1 On receipt of the SAB Chair's decision to undertake a SAR, the SARG Chair and the SAB Board Manager 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 (use the template letter attached as **appendix 3)**

- Considering an initial scope and timescales (see **point 20** Terms of Reference)

- Initiating any information requests that are required from the agencies

- Considering media and communication strategies

19.2 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.

19.3 When agencies are informed that there is to be a SAR they must give this their upmost priority and ensure the information requested of them is completed in a timely manner.

## 20. Terms of reference for the SAR

20.1 When agreement has been reached that there will be a SAR, the SARG or SAR panel will need to draw up the terms of reference. In drawing up the terms of reference consideration should be given to the findings from information already seen or known and the concerns of staff, the adult, family members and others. Consider the following in agreeing terms of reference:

- What appear to be the most important issues to address
- What timescale should the SAR consider
- Which organisations are to be involved
- Is legal or other advice required (media?)
- How are adult/family/advocate to be involved and who will be the most suitable person for this role
- Are independent experts required
- Are there any specific considerations around ethnicity, religion, disabilities etc that need considering.
- If possible involve the family in setting the terms of reference
- Identifying care and service delivery issues, along with the factors that might have contributed to them

The enquiry should stay within the terms of reference unless the terms are renegotiated with the SARG/Panel chair.

## 21. Engagement of the adult, family or advocate

21.1 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 2014, where an adult has "substantial difficulty" in participating, this should involve representation and support from an independent advocate.

21.2 The SAR Review 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.

21.3 The adult, a family member/friend representing them or an independent advocate will be notified in writing that a decision has been made to undertake a SAR. A letter will be sent from the Chair of the SAB explaining why the SAR is being undertaken and will provide a contact telephone number for the adult to speak to discuss whether they would like to be involved and offering support throughout the process. The standard template letter should be adapted to the individual circumstances of the case and sent to the most appropriate person. The template letter is attached as **appendix 3**.

21.4 Along with the letter there is an information leaflet for families which may help people understand what the review process is about and whether they would like to be involved. The person who has built up the best relationship with the adult or the family should be the named contact for their involvement. The information leaflet for families is attached as **appendix 4.**

## 22. Interface with other reviews and investigations

22.1 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 (SIs), Learning Disabilities Mortality Review (LeDeR programme) criminal justice processes and Coroner inquests.

22.2 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.

22.3 Where there are possible grounds for more than one type of review 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.

22.4 If a different type of review has already commenced then the SAR panel may wish to allow that review to conclude, to await the outcomes to see if all the relevant learning has been identified from that review to enable them to decide whether there would be any benefit in undertaking further review.

22.5 Likewise, if a different type of review has recently completed then the SAR panel may wish to review the findings of that review to enable them to decide whether there would be any benefit in undertaking further review.

22.6 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 Review Panel to ensure the necessary contacts are maintained with appropriate people.

## 23. Disclosures to regulatory bodies

23.1 Should it become known during a review that a referral should have been made to a professional body regarding an individual's actions; the most appropriate member of the SARG will make representations to the employing organisation for that referral to be made. If the employing organisation fails to make the referral or the SARG considers there is unnecessary delay than the Safeguarding Adults Board Manager, or other appropriate member will make the referral to the professional body on behalf of the SARG.

## 24. Headline messages

- Prioritisation
- Objectivity/independence
- Proportionate
- Collaborative
- Participative
- Accountability

The SARG should use the information in the attached **appendix 1** to help decide on the most suitable option.

## 25. Guidance for staff involved in a SAR/LLR

### 25.1 Some tools and techniques for staff

25.2 There may be occasions when the agency chronologies and associated action plans do not provide adequate assurance to the Board that the required changes and learning from enquiries has taken place and as such a learning event or similar activity is agreed as a way forward.

25.3 When this is the case there are a number of tools and techniques which can be used to help run successful facilitated learning events. They can be used independently, used collectively or alongside other techniques already used within agencies.

### 25.4 Essential preparation work for a successful learning event

- Assessment of pre-existing material
- Focus on what happened and not why
- Critical appraisal of each agency chronology
- Familiarisation with core local and national documents
- Seeking additional information from professionals or specific agencies in advance of a learning event
- Pertinent conversations with team leaders/managers
- Construction of a composite chronology – display and print ready
- Preparation of attendees
- Venue and administration considerations

### 25.5 Guiding Principles for all SARs/LLRs

- To ensure the maximum amount of **learning** from undertaking the review.
- To nurture a culture of **openness** in reporting, investigating and reviewing incidents.
- To **engage** where appropriate with the adult at risk of harm or their family as appropriate throughout the review using the Mental Capacity Act when required.
- To ensure **quality** in both the review process and in the services delivered as a result of reviews undertaken.
- To ensure **continuous improvement**.

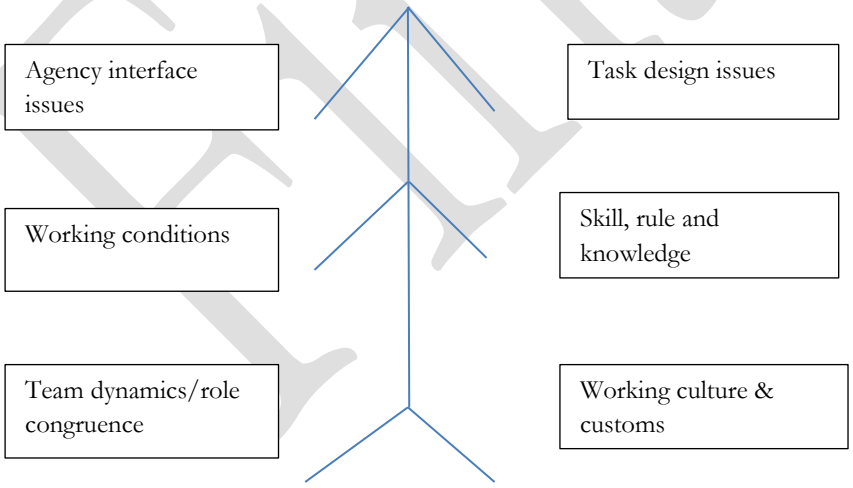
### 25.6 Resolving Inter Agency Disputes

If a partner agency does not agree with the decision to undertake a SAR this will be escalated following the guidance outlined in the document *Resolving Inter Agency Disputes*. This is found in **appendix 6.**

### 26. The Fishbone analysis

26.1 This technique can be used where there have been serious lapses in practice and or systems or processes. A dedicated facilitated session (half or full day) can be used to complete the illustrated fishbone using the information obtained from the chronologies.

Using existing chronologies complete the fishbone:




26.2 More fish bones can be added if there are different emerging issues. Others which are recognised and have been widely used particularly in the NHS include: Individual task issues (such as ill health, stress, and personal issues), Management issues (such as culture, supervision, caseload management), Working conditions (such as skill mix, workplace layout, heat, light, caseload size)
Simply create your own fishbone.

26.3 Use a large flip-chart paper and complete the issues for the case being reviewed as a group exercise. Each area identified can then be further developed into areas which require an action and transferred to an action plan.

26.4 Individual agencies can complete a fishbone or alternatively one can be completed as part of the learning event using the combined chronology along with participants' verbal input.

26.5 There should always be a list of recommendations and an action plan as a result of this exercise. This will be then monitored by the SAB.

## 27. Private post-box method

27.1 There are times when some individuals may feel a group input session is too daunting especially when an incident under review directly involved them. Opportunities should be made to allow such individuals to contribute their feelings, thoughts and opinions on what happened through private methods such as the method illustrated below.
To avoid identification of individuals wanting to use this method only the post-boxes can be placed in the same room as the learning review is taking place to allow any other participants to use this method also.

27.2 It would be helpful to ask those who do use this method to add their name and contact number to any contributions they make so that should they be required to be interviewed as part of the review they are able to be identified.

This additional method should be introduced at the beginning of the learning event.

See the illustrations below.

## Another facilitation tool that aids enhanced interactivity under challenging circumstances

**Private Post Box Method:**

Each box can be labelled depending on the incident or information already known or gleaned from the chronologies such as

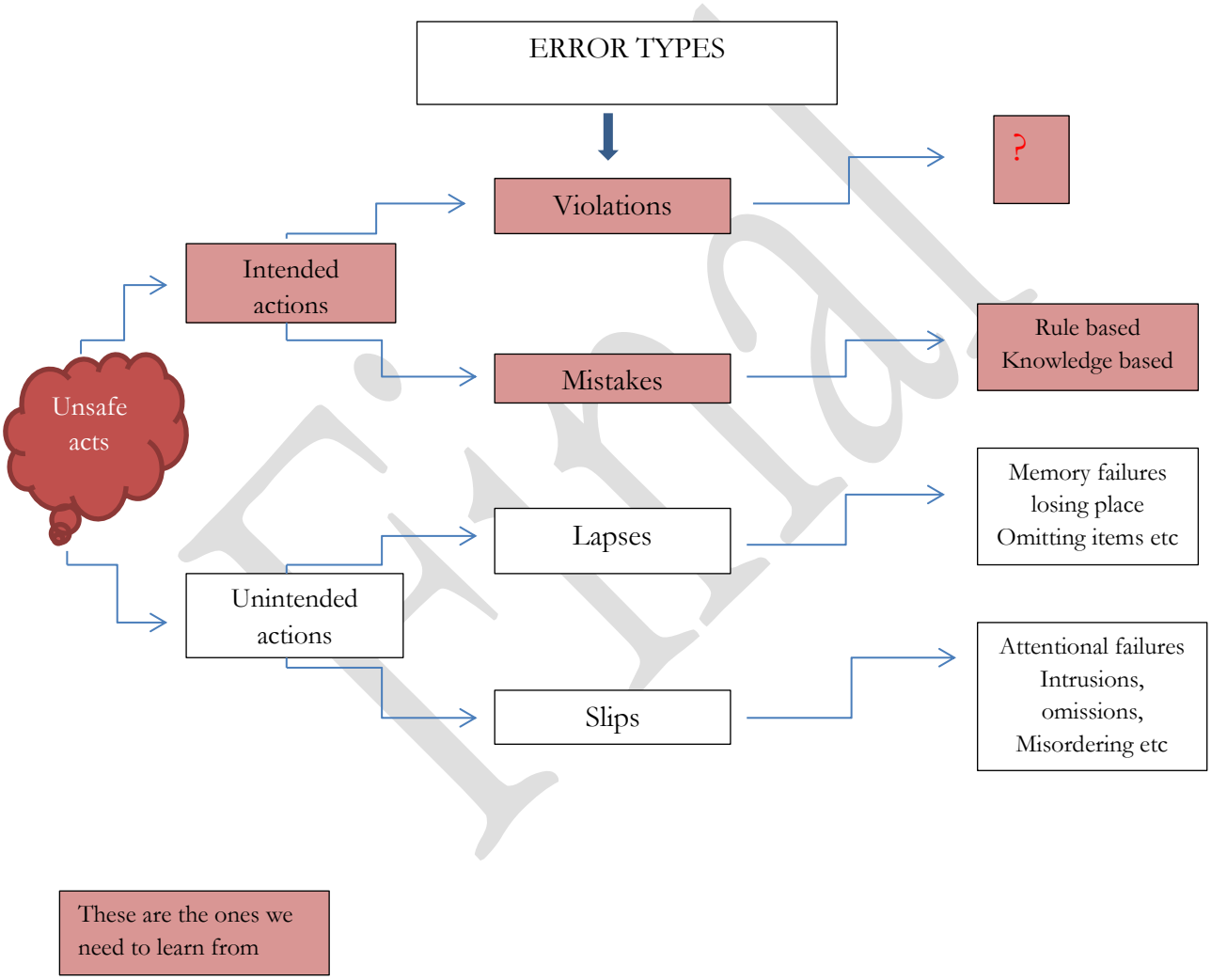
- Communication issues
- Staffing/team issues
- System issues
- Policies and procedures ( followed/not followed)

Alternatively one box can be placed at the back of the room and the lead facilitator sorts them and includes the issue within the write-up of the learning event.

## 28. Identifying lapses and error types

28.1 Although multi agency learning events present a superb opportunity for group reflection and learning they are not without their challenges if serious lapses have occurred in one or more agency.

28.2 Knowing about these before the event is very useful as it enables you to consider what can and cannot be discussed in the event, or it enables you to think about the approach you might take and the group work tools you might employ to support the event and its success.
Visual aids which include the identification of known errors from the incident may make the learning event less personal. Here is an example which could be used:



## 29. Data collection

29.1 The types of data collected and analysed should have been completed by each agency as part of the chronology writing and must be saved so that it can be referred back to is required. This should include data/records from

- Organisational recording systems (paper based and electronic) including care records, case notes, diary records,
- Staff rotas and time sheets
- Staff records such as training records, qualifications and experience, personal development plans, sickness records
- Nutrition/hydration records
- Visitor books
- Policies and procedures

29.2 If there are any further queries or questions raised as part of the analysis of the chronologies by the review panel then there may be a need to undertake further data collection at a later date. The panel may also wish to send a member of their review team into one or more of the agencies involved to look again at any data which has been collected as part of the earlier stages of the review. Agencies should accommodate this in a timely manner.

## 30. Interviewing core staff, the adult, family members and others who were involved

30.1 Most SARs/LLRs will involve a member or members of the panel interviewing key members of staff, family members, others such as witnesses who were involved in the case at the time.

The added benefits of interviewing are that it:

- Allows careful exploration of issues on a 1:1 basis
- Allows sensitive issues to be discussed in private
- Facilitates professional check and challenge with a subject matter "expert"
- Enable the reviewer to gather good quality information and cross check data.

Staff who have left the organisation since the incident can still be invited to take part.

30.2 Interviewers should be skilled and preferably have undertaken formal recognised training in conducting investigative interviews.
There are a range of supportive documents available to download free of charge to support practitioners in interviewing. A particularly helpful guide is available at; https://www.app.college.police.uk/app.../investigations/investigative-interviewing/

## 31. CCTV/Photo evidence

31.1 Issues captured on CCTV will also hold some vital clues in to what happened at a particular time and location. CCTV may capture other people who were around at the time of the incident and can then be called upon to be involved in the SAR.
Similarly if the incident is unique to a particular location/site there may be some benefit in going to that location and taking photographs to add to the information captured for the SAR.

## 32. The conclusion of the enquiry process

### 32.1 The final report

32.2 The SAR/enquiry concludes with an investigation report and action plan. This needs to be written as soon as possible and in a way that is accessible and understandable to all readers.
The report should:

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials and document name;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest (seek legal advice);
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable;
- Include a description of how patients/victims and families have been engaged in the process;
- Include a description of the support provided to patients/victims/families and staff following the incident.

## 33. Action Plan

33.1 The minimum requirements for an action plan include the following:

- Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (not an investigator who has nothing to do with the service although clearly their recommendations must inform the action plan);
- Every recommendation must have a clearly articulated action that follows logically from the findings of the investigation;
- Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the 'root causes' /most significant influencing factors) which resulted in the lapses/acts/omissions in care and treatment identified as causing or contributing towards the incident;
- A responsible person (job title only) must be identified for implementation of each action point;
- There are clear deadlines for completion of actions;

33.2 A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound.

## 34. SAB Function after a SAR

34.1 The SAB will monitor the action plan until all actions have been completed and closed. There is an expectation that agencies who are named in the action plan will provide quarterly updates and/or report verbally at the SAB quarterly meetings.

34.2 The template action plan used previously in this guidance can be used again to develop the final SAR/LLR multi-agency action plan.

## 35. Feeding back the findings to the adult, family and others

35.1 The final report should be produced in an accessible format. If the adult, their family, friend or another nominated person has been involved in the SAR process they will be written to and informed that the SAR has completed and a report has been produced.

35.2 They will be offered the opportunity to have a meeting with the most appropriate person to go through the findings of the SAR and to tell them about any next steps.

35.3 If the adult, their family member or friend does not feel there is a need for a meeting they will be sent a copy of the report through the post.

## 36. Sharing the Lessons learnt

36.1 The fundamental purpose of undertaking a review of any description is to identify lessons to be learnt to improve learning and develop practice across multi-agencies to safeguard other adults and children at risk of harm and abuse.

36.2 For all cases reviewed under these procedures lessons learnt will always be drawn out into a document. Depending on the types, number and themes of these lessons they may be shared by any or all of the following routes:

- Sharing as an article on the Safeguarding Adults Board newsletter
- Sharing on the SAB website under a lessons learnt section
- Sharing by multi-agency partners such as via bulletins, group email etc
- Sharing at national level as relevant such as with CQC, NHS England
- Sharing via the level 3 training course (The Role of the Manager) which is run by the SAB

36.3 As well as the sharing, the SAB will also create and maintain a lessons learnt log which will be updated by partner agencies and monitored by the SAB.

**Appendix 1**

**Safeguarding Adults Review (SAR) Methodologies**

**Methodologies**

There are many ways to achieve learning; guidance from the Association of Directors of Adult Social Service (ADASS) and the NHS emphasises the importance of proportionality in conducting reviews, and with this in mind flexible options are available to match the circumstances of the case.

Each methodology is valid in itself, and no approach should be seen as more serious or holding more importance or value than another.

The focus must be on what needs to happen to achieve understanding, remedial action, and, very often answers for families and friends of adults who have died or being seriously abused or neglected.

This procedure offers three possible options.

**Option one – Action Learning Approach (this is also known as a "systems model")**

This option is characterised by reflective/action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

The broad methodology includes:

• 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 – may be commissioned or internal with appropriate skills.

• Production/review of relevant evidence, the prevailing procedural guidance, summary of events and key issues from designated agencies via chronologies.

• 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 Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation.

• Follow up event to consider action plan recommendations.

• Ongoing monitoring via the Safeguarding Adults Board.

**Option two – Root Cause Analysis**

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If the contributory factors and causal factors - the root causes - of an incident or outcome are understood, corrective measures can be put in place. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. This approach can help to prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

**General principles of Root Cause Analysis:**

 RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes.

 To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence.

 There is usually more than one potential root cause of a problem.

 To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause(s) and the incident, not just the obvious.

NHS organisations routinely carry out RCA reviews into serious incidents or near misses and therefore when a case involving an adult requires review of single agency NHS care only this will be the recommended method. Quite often when incident had been reviewed through RCA no further review is required.

**Option three – chronologies, analysis & learning lessons review (LLR)**

This is a well-known traditional method of undertaking reviews. The chronology and analysis documents are often used interchangeably as a review process; however they can also be used as separate entities if the learning has been successfully identified through the completion of a single document by each agency concerned.

Chronologies enable organisations to reflect and critically analyse their involvement in a case, to identify good practice and areas where systems, processes or individual and organisational practice could be enhanced. They are used in many reviews including SARs, SCRs, DHRs etc and they can be used in a multiple or single agency environment.

They should provide a critical analysis of the organisations management of the case and identify the lessons learnt and actions taken or to be taken.

They are not simply a narrative of what happened and when.

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

Chronologies are important tools particularly when combined across organisations. They enable a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment. They are useful when an adult has received services from multiple services such as primary care, secondary care, social services, community-based services as it enables all services to look critically at their interventions, decisions made and actions taken with the adult and ask themselves if they would have done anything different on reflection. They can also be produced if there is more than one adult being reviewed.

Where there is more than one agency involved a combined chronology is produced which can then be used for further discussion and analysis in a **desk-top learning event.** The desk-top learning event can be used for two purposes:

- To develop an action plan and recommendations which can then be monitored by the SAB.
- To decide whether there is further need for a much bigger multi-agency workshop if it is felt that this is required. This would benefit from an experienced facilitator.

There are similarities to the first option, the action learning approach however there may be less need to undertake some of the more time-consuming elements such as the follow-up events, appointment of an independent author as the chronologies and analysis may be enough to develop a proportionate review which is less resource intensive.

Whichever process is chosen any identified learning points should be noted and translated into actions which are shared with the SAB and implemented.

**Appendix 2**

| **SAR Referral Form** |
|---|

**Referrers' Details**

| **Name** | **Designation** | **Agency** | **Contact details (email & telephone)** |
|---|---|---|---|
| | | | |

**Details of the adult at risk – complete all the information known to you at this time**

| | |
|---|---|
| **Name** | |
| **Date of Birth** | |
| **Date of death (if the adult has died)** | |
| **Date of incident** | |
| **Gender** | |
| **Ethnicity** | |
| **Address** | |
| **Brief details of the adults physical health** | |
| **Brief details of the adults mental health** | |
| **Agencies involved with the adult** | |

**Details of the person/s or organisation/s alleged responsible to have caused the harm or neglect – please provide the details known to you at this time**

| | |
|---|---|
| **Name/s** | |
| **Address** | |

**Family and significant others**

| Name | Relationship to adult |
|---|---|
| | |
| | |
| | |
| | |

**Please outline the circumstances of the incident (death, injury, referral to safeguarding). Include in this section what happened, where it happened, what are your main concerns and if possible include dates, times and locations. If you are aware if a safeguarding enquiry/S42 or any other type of enquiry has already taken place please also include details.**

| Circumstances of the incident: |
|---|
| |

**Add additional sheets as required**

**Your agency's & other agencies involvement with this adult.**
**Outline below your agency's involvement with the adult at risk, their family, carers and any other significant people. Also include areas of concern about other agencies involvement/lack of involvement which may have impacted on this incident.**

| **Agencies involvement with the adult:** |
|---|
| |

**Is the adult/family/advocate aware that this request for a SAR is being made (if applicable?)**

**Yes** ☐ **No** ☐

**Criteria for undertaking a Safeguarding Adults Review:**

**Please tick the appropriate box that explains why this case requires a Safeguarding Adults Review:**

| **Tick √** | **Criteria relevant to this case** |
|---|---|
| | An adult at risk has died 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. |
| | An adult at risk has not died, but the Safeguarding Adults Board knows or suspects that the adult at risk has experienced **serious** abuse or neglect. |
| | The SAB are also free to consider conducting a SAR into any incident(s) or case(s) involving adults at risk. E.g. where it is believed to be in the public interest to conduct such a review. |
| | The request is being made by a Coroner, Family, Government Ministers or other interested parties seeking a SAR to establish whether there are important multi-agency lessons to be learned. |

**Email the completed form to: sab@eastriding.gcsx.gov.uk**

**Appendix 3**

**Standard Template letter to the adult or family member/advocate**

Addressee
Date

**Re: East Riding Safeguarding Adults Board – Safeguarding Adults Review (SAR)**

Dear

(In the case of a death only) First of all I would like to offer my sincere condolences on the death of (adult's name).

The purpose of this letter is to inform you that because of **(insert circumstances)** ********** and the circumstances surrounding this, East Riding Safeguarding Adults Board (SAB) will carry out something called a Safeguarding Adults Review.
I would like to reassure you that this Safeguarding Adults Review will not influence any ongoing police investigations, or any work that may be happening at the moment between your family and professionals such as a social worker. This is a separate process, involving senior managers from all Health and Social Care Services that make up the SAB.
The purpose of the Safeguarding Adults Review is:

 To establish whether there are lessons to be learned about the way in which local professionals or organisations work together to safeguard and promote the welfare of adults at risk

 To identify clearly what those lessons are, how they will be acted upon and what changes might be necessary

 To improve inter agency working and better safeguard adults at risk.

I have enclosed a leaflet which outlines the process for the Safeguarding Adults Review.
Please do not hesitate to contact xxxxxxxxxxxxxxxxx if you would like to be involved in the Safeguarding Adults Review so we can discuss how you would like involving, or if you want any further information.
You may want to take independent legal advice before making any decisions about all of this. If you decide to do this and your solicitor has any queries he or she is also welcome to contact the above mentioned person.

Yours sincerely

Chair of the SAB

**Appendix 4**

**Leaflet for Families**

## Safeguarding Adults Reviews: Information for Families

### What is East Riding Safeguarding Adults Board (SAB)?

East Riding Safeguarding Adults Board brings together all the main organisations who work with adults at risk and their families in our area to keep them safe.

### What is a Safeguarding Adults Review?

A Safeguarding Adults Review looks at how local organisations worked together to look after the adult at risk at the centre of the review. It may also look at how they are working with other adults at risk in the immediate family or care settings. The review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is not a Criminal Investigation or Public Enquiry and its aim is not to place blame but to learn.

### Why Are You Carrying Out A Safeguarding Adults Review?

East Riding Safeguarding Adults Board will carry out a SAR whenever an adult at risk has been seriously harmed or has died in circumstances where abuse or neglect is suspected or confirmed. There is an Act called the Care Act 2014 which states the cases in which we **must** carry out a review and this case meets the criteria.

### Who Will Carry Out the Review?

A panel of professionals from Community and Adult Care Services, the Health Service, the Police and sometimes other organisations are led by an independent person (the 'Author'). They will meet to review reports from each organisation or agency which has worked with or provided services to the adult at risk or their family. The Author will prepare a report. This report will say what lessons have been learnt and make recommendations for East Riding Safeguarding Adults Board.

### What Will Happen after the Report is finished?

East Riding Safeguarding Adults Board will write an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. Each individual organisation involved in the review will also write an action plan. East Riding Safeguarding Adults Board will make sure the actions are carried out and have a positive effect.

### What Will I / We Have To Do?

You do not have to do anything. However, you will have the opportunity to give your views if you would like to. We will make sure that there is someone who can help you to do this (see contact details below).

### Who Will See the Report?

Normally the Report will be kept confidential to those people who represent their organisations at East Riding Safeguarding Adults Board or have contributed to the review and the staff within those organisations who worked with the adult at risk and their family. The Executive Summary sets out the key findings and recommendations of the review. It does not give any personal details or information which would identify the adult at risk, family or anyone else involved. It is available to

anyone who wants to read it and will be on our web site. Your personal contact will meet with you and tell you what is in the Executive Summary before it goes on the website.

## How Long Will the Review Take?

The review will be undertaken as quickly as possible. However, in some cases it can take six to nine months from the start of the review to publication of the Executive Summary.

In this leaflet we have answered some of the most frequently asked questions families have about Safeguarding Adults Reviews. Of course, each case is different and you may have other questions you would like to ask. If so, you can contact the person named above in your letter or you can contact the Safeguarding Adults Board Manager.

East Riding Safeguarding Adults Board
01482 392092
Email: ersab@eastriding.gcsx.gov.uk

**Letter to agencies**

**Appendix 5**

Independent Chair
Safeguarding Adults Board
County Hall, Cross Street,
Beverley.
HU17 9BA

Insert date

**Strictly Confidential**

Chief Executive Officer
Agency Name
Address line 1
Address line 2
Town
Post code

Dear (insert name)

**Re: Safeguarding Adult Review-Adult at Risk of Harm.**

The purpose of this letter is to notify you that it is the intention of the East Riding Safeguarding Adults Board (SAB) to undertake/commission an Adult at Risk of harm Safeguarding Adult Review (SAR) and your agency may be able to contribute/support the review process. Your East Riding Safeguarding Adults Board representative (insert name) has been sent a similar communication via email; the subject matter of this letter is not in the public domain.

Following a recommendation by the SAB Safeguarding Adult Review Sub-Group, I decided that a Safeguarding Adult Review will be required to examine the way agencies worked together to safeguard (insert very brief details of case ).

The subject of the review will be: Insert adults name

DoB:

Terms of reference, appointment of independent chair/report author and membership of the Case Review Panel will be agreed and circulated in due course. At that time it may be necessary for your agency to identify a manager (or independent person) of sufficient seniority and experience to take part in the review. The manager appointed should have had no line management relationship with practitioners working with the person concerned or any direct contact themselves with the adult at risk of harm. It would be helpful if they have had some experience in undertaking reviews.

The purpose of a safeguarding adult review is to establish whether there are any issues in relation to inter-agency working under the local safeguarding adults procedures, and if there are any

lessons to be learnt about the way they operated. To achieve this, each agency that has had involvement is required to look openly and critically at their professional practice with the adult concerned.

I will ensure your board representative is contacted in due course with an update in respect of the terms of reference and the necessary next steps. Should you require further information before then please feel free to contact me.

Yours Sincerely

Independent Chair

East Riding Safeguarding Adults Board

Email:

**Contact Officer**

Board Manager

East Riding Safeguarding Adults Board.

Tel:

Email:


*Safeguarding is everybody's business*

# RESOLVING INTER-AGENCY DISAGREEMENTS



Guidance and Protocol, including Escalation, for use by staff from all agencies

February 2016

**Introduction**

Generally there are good working relationships between agencies, but occasionally there will be a difference of professional views. This protocol describes the actions required within the East Riding of Yorkshire where there is a professional disagreement about what action should be taken.
Good practice includes the expectation that constructive challenge amongst colleagues, within agencies and between agencies, is in the best interests of vulnerable adults. Where members of staff from any agency believe concerns regarding a vulnerable adult are not being addressed it is expected that the escalation process will be used until a satisfactory conclusion is achieved. All ERSAB partner agencies have agreed to the use of this protocol and expect staff to use it in appropriate circumstances.
The vulnerable adult's safety and wellbeing must be the paramount consideration at all times and professional differences must not distract from timely and clear decision making.
Occasionally situations arise when workers within one agency feel that the actions, inaction or decisions of another agency do not adequately safeguard a vulnerable adult.

Disagreements are most likely to arise around:

- Levels of need/thresholds
- Concern about the response of a key agency to a reported concern
- Lack of clarity about roles and responsibilities
- Decision making
- Progressing plans
- Communication

All professionals have a duty to act assertively and proactively to ensure that adult safeguarding is the paramount consideration in all professional activity. All professionals must challenge the practice of other professionals where they are concerned that this practice is placing vulnerable adults at risk of harm. Resolution should be sought within the shortest timescale possible to ensure the vulnerable adult is protected.

Disagreements should be resolved at the lowest possible stage however…

| |
|---|
| If, during a dispute with another agency about what action should be taken, a vulnerable adult is thought to be at risk of immediate harm the designated safeguarding lead in your agency should be consulted immediately for further advice. |

**The importance of reducing the likelihood of having to escalate**

Transparency, openness and a willingness to understand and respect individual agency views are core aspects of a safe multi-agency and inter agency safeguarding service.
Good preparation, planning and a willingness to listen to the views of others, even if they appear challenging of your own views, will ensure that disagreements are kept to a minimum

Effective communication requires a culture of listening to and engaging in dialogue within and across agencies. It is essential that all communication is as accurate and complete as possible and clearly recorded, in line with individual agency procedures.
Accuracy is essential for without it effective decisions cannot be made and equally, inaccurate accounts can lead to vulnerable adults remaining unsafe, or to the possibility of wrongful actions being taken that affect those at risk of harm.

At all stages of the process actions and decisions must be recorded in writing by the agencies involved and shared with relevant personnel including the worker who raised the initial concern. There must be written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued. How this is undertaken should be determined in each case.

**Timescales**
Resolution needs to be found within timescales that are linked to the needs of the vulnerable adult, not the convenience of professionals. When disagreements need to be resolved very quickly in order to safeguard a vulnerable adult professional judgement should always be used.

For a variety of reasons there may be a delay at any stage, for example responding to telephone calls or emails. When this occurs careful consideration should be given to involving managers at the next level of the structure by letting them know there is a disagreement, that a speedy response is required to safeguard the vulnerable adult and that in the absence of such a response, they will be contacted to help progress the disagreement further.
The maximum timescale for completion of a dispute up to Stage 4 is **5 days.** In the rare circumstance that Stage 5 has to be employed this should be begun 5 days from the original dispute being raised and completed within a further 5 days.

**Dispute Resolution Stages**

**Stage One – involving your line manager**
Any worker who feels that a decision is not safe or is unsatisfactory or inappropriate should initially consult their own supervisor/manager to clarify their thinking in order to identify the problem, to be specific as to what the disagreement is about, and to identify the desired outcome.

**Stage Two – involving the worker from other agency/service**
The people who disagree should have a discussion to resolve the problem. This discussion must take place as soon as possible and could be a telephone conversation or a face to face meeting. There may be instances where disparity in perceived status or experience may inhibit the ability of some workers to resolve the disagreement without support. This should be seen as acceptable, rather than an escalation in itself.

**Stage Three – escalate line manager to line manager**
If the problem is not resolved at stage two the worker should contact their supervisor/manager within their own agency who should have a discussion with the equivalent supervisor/manager in the other agency.

**Stage Four – escalate to named/designated safeguarding leads or senior operational managers.**
If the problem is not resolved at stage three the supervisor/manager should raise the issue with their respective operational manager or named/designated safeguarding representative. The issue should be discussed with a senior manager at the appropriate level in the other agency and a resolution agreed. If the issue cannot be resolved then consideration should be given to progressing the dispute through senior management up to Head of Service or Director level or equivalent.

In situations where senior officers have become involved in resolving disagreements between agencies and those disputes relate to the safeguarding needs of individual vulnerable adults, the ERSAB Team should be made aware of this. The purpose of such notification is to help monitor interagency safeguarding activity, and to identify issues which may benefit from an ERSAB Quality Assurance scrutiny. The agency which found it necessary to escalate an issue to such a high level in another organisation should advise the other organisation of their intention to do so and complete appendix A and return it to the ERSAB Team.

**Stage Five – resolution through mediation using an East Riding Safeguarding Adults Board (ERSAB) chaired meeting**
Operational issues must be resolved by the agencies identified directly involved in the case. When a resolution has not been achieved at stage four, the Chair of the ERSAB should be approached to identify a Board member from an uninvolved agency to chair a meeting of the most senior managers with operational responsibility for the case. This meeting will review the issues at hand and provide a final opportunity for the involved agencies to ensure that there is a full understanding of the issues before the decision is finalised.

The Chair of this meeting will then report on issues arising from this process to the ERSAB Business Implementation Group

**Disagreements in specific circumstances:**

**Where there is an immediate adult safeguarding concern**
Where there is an immediate safeguarding concern under Section 42 of the Care Act of 2015, the Local Authority Adult Services have lead responsibility for decision making regarding the level of need of the vulnerable adult.

**Differences of Opinion regarding Vulnerable Adult Professional Meeting**

Where there is disagreement about whether a vulnerable adult should be the subject of a vulnerable adult professional meeting the existing ERSAB policy and procedures should be followed.

Sharing information and reports prior to professional meeting will highlight potential areas of difference to the meeting Chair. The service user's social worker should also discuss potential areas of conflict with the meeting Chair in advance.

Differences in view arising during professional meetings should be managed by the meeting Chair. If the issue is not resolved, the meeting should be adjourned for a maximum of 72 hours and the Chair should discuss the matter with the named Senior Managers from each agency. In the interim period the vulnerable adult should be the subject of a Vulnerable Adult Risk Management. If there is still no resolution, the ERSAB should be asked to arbitrate. The areas of disagreement should be recorded on the meeting minutes along with the final decision and must include evidence of all attempts to agree the matter prior to the meeting adjournment.

**Learning lessons**

Consideration should be given as to whether lessons can be learned from the process of dispute resolution, either on a single or inter agency level.

For example:

- Identification of training needs
- Commissioning needs
- New agency practice guidance
- New ERSAB practice guidance

Where an agency/ agencies think that there could be lessons to be learned on a multi-agency level following the resolution of a disagreement, details of the resolution should be forwarded to the East Riding Safeguarding Adults Board Manager for consideration of any multi-agency learning.

**East Riding Safeguarding Vulnerable Adults Board**

**RESOLVING INTER-AGENCY DISAGREEMENTS**

## Appendix A - Stage 4 Monitoring Information

The ERSAB should be informed if a case reaches Stage 4 by returning this completed document to: ERSAB, Room GF56, County Hall, Beverley HU17 9BA

or email to: sab@eastriding.gcsx.gov.uk (for the attention of the ERSAB Board Manager)

**Date of Referral:**

**Name of Referrer:**

**Job Title:**

**Agency?**

**Address/Email Address:**

**Service User Details**

**First name and Surname**

**DOB**

**Address:**

**Agencies Involved: in the dispute or in the case generally?**

**Issues of Concern/Nature of Disagreement:**

**Dates and Outcome of Stages 1,2 and 3:**

**Stage 4 Meeting/Discussion Date:**

**Names of Senior Officers involved at Stage 4 and their agency**

**Outcome**