Kirklees Safeguarding Adults Board

Partners in preventing abuse and neglect

## Kirklees Safeguarding Adults Board

# Safeguarding Adults Review Framework

This document sets out how to request and conduct Safeguarding Adults Reviews in Kirklees under Section 44 of the Care Act 2014.

20-06-2022

# KIRKLEES SAFEGUARDING ADULTS BOARD

# SAFEGUARDING ADULTS REVIEW FRAMEWORK

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## 1. INTRODUCTION

1.1 Section 44 of the Care Act 2014 and associated statutory guidance require Safeguarding Adults Boards (SAB) to conduct Safeguarding Adults Reviews (SARs) in certain circumstances and permits the SAB to arrange them in other circumstances. The Act requires SAB member agencies to cooperate with and contribute to the carrying out of a SAR.

1.2 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."***
> Care and Support Statutory Guidance (DH: 2010) paragraph 14.164

1.3 The purpose and underpinning principles of SARs, and the broad requirements and guidance for conducting SARs for Adults at Risk are set out in section of the Joint-multi-agency-safeguarding-adults-policy-procedures-2019-20-21. This policy and procedures document has been adopted by Kirklees SAB and provides the overall governance of our SAR approach.

1.4 The main methodological options for conducting SARs are set out in Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015).

1.5 This SAR framework therefore acts as an appendix to these documents and must be read in conjunction with them.

1.6 The framework sets out:

- the criteria for when Kirklees SAB must or may commission a SAR
- the processes for requesting and commissioning a SAR
- an enhanced menu of options for conducting SARs and detail of how to implement each option
- a decision tree for selecting a SAR methodology appropriate to the case under review
- how adults at risk and their families and staff involved will be supported in SARs
- how learning from our SARs and from other SARs nationally will be acted on in Kirklees; and
- templates for letters, terms of reference and reports.

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

- ensure local processes comply with legal requirements and best practice, incorporating the SAR Quality Markers
- enable a consistent approach to SAR decision-making and practice
- guide the SAB and local agencies involved; and
- set out how effective SARs serve the public interest and encourage learning.

## 2. CRITERIA FOR SARs IN KIRKLEES

2.1 The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

2.2 **A SAR must always be conducted**[1] (statutory SAR) when:

- There is reasonable cause for concern about how the SAB, 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 SAB knows or suspects that the death resulted from abuse or neglect including Self-Neglect (regardless of whether or not the abuse or neglect had been reported); OR

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

2.3 "Serious abuse or neglect" may include:

- the individual would probably 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
- 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 SAB Independent Chair following initial discussions and consideration by the Boards SAR subgroup as to whether abuse/ neglect was serious enough to warrant a SAR.

2.4 Where the person is alive, is enough known about their experience to explore the impact of the abuse and/or neglect in a person-centred way, which may include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness?

2.5 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.

2.6 A discretionary SAR may be arranged by Kirklees SAB for any other case involving an adult in its area with needs for care and support. A discretionary 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. (Section 44 (4) Care Act)

[1] Care Act, Section 44

2.7 Some examples of appropriate cases for a discretionary SAR may include:

- Serious incidents that do not meet the criteria for a statutory SAR but that Kirklees SAB wants to review
- A case featuring repetitive or new issues which the SAB wants to review in order to proactively identify areas of practice or issues to prevent serious abuse or neglect arising.
- A case featuring good practice in how agencies worked together to safeguard, from which learning can be identified and applied to improve practice and outcomes for adults.
- Considering links to LeDeR process. LeDeR is a service improvement programme for people with a learning disability and autistic people. A SAR always takes priority due to its statutory status. Within the agreed methodology of a LeDeR, the reviewer is expected to contact the SAR lead and agree if the LeDeR can proceed or to be put on hold which is often the case (pending the outcome of the SAR)

2.8 In instances where there is a disagreement in the decision making refer to section 2.1 of the SAR Quality Markers.

## 3. REQUESTING A SAFEGUARDING ADULTS REVIEW

3.1 Kirklees SAB is the only body that commissions SARs of adult safeguarding cases in Kirklees.

3.2 **Any agency, professional or individual can use the process outlined below** to request a SAR on a case believed to fit the criteria listed in section 2. A flowchart of the process is available at Appendix 1.

3.3 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 SAB will then make the SAR request to the SAB.

3.4 If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. NHS serious incident investigation, LeDeR Process) this should take place as a matter of priority, Internal governance processes and multi-agency reviews are not mutually exclusive, so a request for a SAR can be made at the same time if appropriate.

3.5 Requests are received securely to KSAB@kirklees.gov.uk using the online SAR referral form. Confirmation of receipt of the request is sent by email to the requestor.

3.6 On receiving a request, the Chair of the SAR Subgroup and SAB Manager will meet to decide whether the criteria for a SAR have been met.

3.7 Relevant scoping documents are sent out to all agencies advising of the required return date and informs the referrer that scoping is taking place. All documents are returned securely and are shared with the SAR Subgroup prior to meeting.

3.8 Once the information is received the Standing Subgroup meets to finalise decision making, in line with the SAR criteria and undertake further scoping using The SAR referral and Decision tool and SAR overview log.

3.9 If appropriate, check the lawfulness of the decision making.

3.10 The Chair of the SAB will ratify the decision of the Standing Subgroup and 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) are to make the necessary arrangements for participation in the SAR, e.g. immediate securing of files and records, nominating a representative for a SAR panel etc. The Chair of Kirklees SAB will also arrange for relevant commissioning and regulatory bodies to be notified that a SAR has been initiated.

3.11 Where the requestor is dissatisfied with this outcome, they should notify the Chair of Kirklees SAB in writing, who will discuss and review (if necessary) the decision with the requestor and the Standing Subgroup.

3.12 If the challenge is upheld the Chair of the SAB will then arrange for a review of the request with requestor and Standing SAR Subgroup.

## 4. MAKING DECISIONS ON SAR REQUESTS

4.1 In deciding whether a SAR should be conducted, the Standing SAR Subgroup must first consider whether there is a statutory obligation to undertake a SAR: using the criteria outlined in paragraphs 2.1 to 2.3 of this framework. A SAR must be commissioned if there is a statutory requirement to do so.

4.2 In deciding whether a SAR should be conducted, is there any cause for concern about the quality of safeguarding practice, paying particular attention to the principles of Making Safeguarding Personal.

4.3 In cases other than those involving a statutory obligation, the panel should carefully consider whether commissioning a discretionary 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 focused on those cases that will yield the greatest learning and practice development.

4.4 Considering the following questions may help to establish whether there are sufficient lessons to be learned and value in commissioning a discretionary 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 persons to have caused harm, 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 differently in the future?
- Would a SAR enable the SAB to identify areas of practice to prevent serious abuse or neglect happening?
- 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 Kirklees 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?

4.5 The SAR Standing Subgroup should also consider whether another review or learning process has already commenced that will identify and share lessons to be learned, or which Kirklees SAB could potentially feed into to avoid duplication (e.g. Domestic Homicide Review or Health Serious Incident process), and provide clarity about any governance issues if other processes are involved.

4.6 If, in making a decision to commission a SAR the SAR Standing Subgroup cannot reach a consensus, the final decision will rest with the Independent Chair of Kirklees SAB

## 5. MAKING A DECISION ON SAR METHODOLOGY

5.1 Once the SAR Standing Subgroup have agreed to commission a SAR, they must decide on the most appropriate methodology to use. This must be appropriate and proportionate to the case under review. 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.[2]
- **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.
- **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.
- **SAR report and recommendations**.

5.2 A decision tree and a menu of options for SAR methodologies[3] is provided in

[2] The majority of skills required of a SAR chair are transferrable from other areas. Analytical skills for SARs can be quite specific. Therefore training (e.g. in SAR techniques and methodologies, accident/ incident investigation and analysis) will be provided by the SAB as required for Board members and staff members who may be nominated as SAR leads or chairs, in order to build capacity in the partnership to undertake effective SARs

[3] Based on options set out in Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015).

section 6. 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.

5.3 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?

5.4 In addition to selecting a SAR methodology, the SAR Standing Subgroup of Board members must also decide:

- Which agencies (including legal, and CQC as required) should be asked to participate in the SAR panel.
- Level of independence from the case required of panel members
- 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.)
- Consideration of how learning will be disseminated and embedded
- The required output from the SAR (e.g., a report).
- Whether an independent author is required, and level of independence.
- Provide clarity over governance issues if there are links to other reviews

## 6. MENU OF OPTIONS FOR SAR METHODOLOGY

6.1 The menu of SAR methodologies[4] set out below includes the following six options:

- Systems analysis
- Learning together
- Significant incident learning process
- Significant event analysis/ audit
- Appreciative inquiry
- Safeguarding Adults Review (traditional methodology)

On the following pages, a process map of each methodology is provided, along with key features to assist decision-making. Links are provided to identified available models, which can be used to download tools and guidance

6.2 The menu is not an exhaustive list. The Standing SAR Subgroup should use its collective experience and knowledge to recommend the most appropriate

[4] Adapted from: Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015)

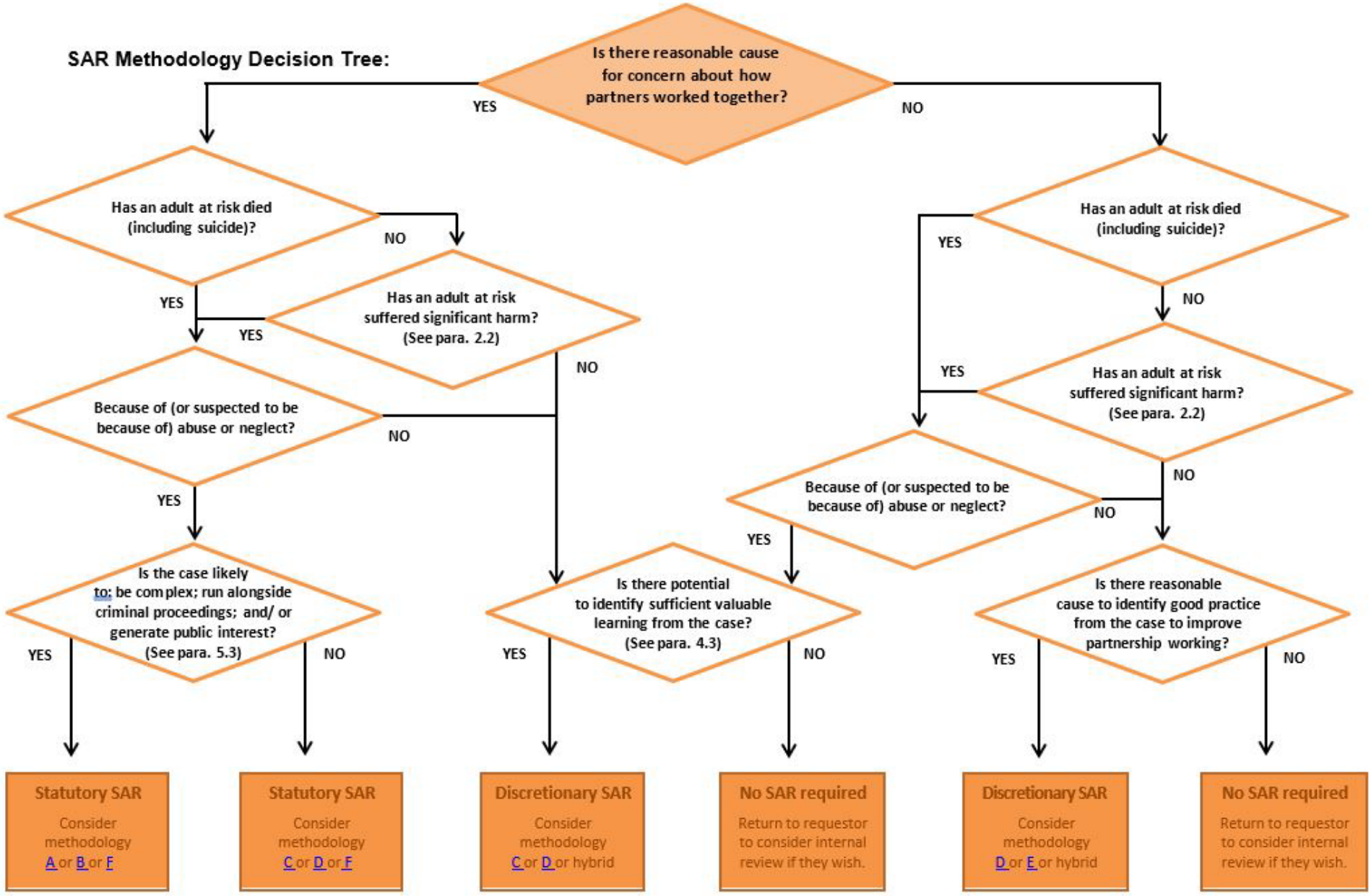
learning method for the case (including hybrid approaches).

6.3 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.

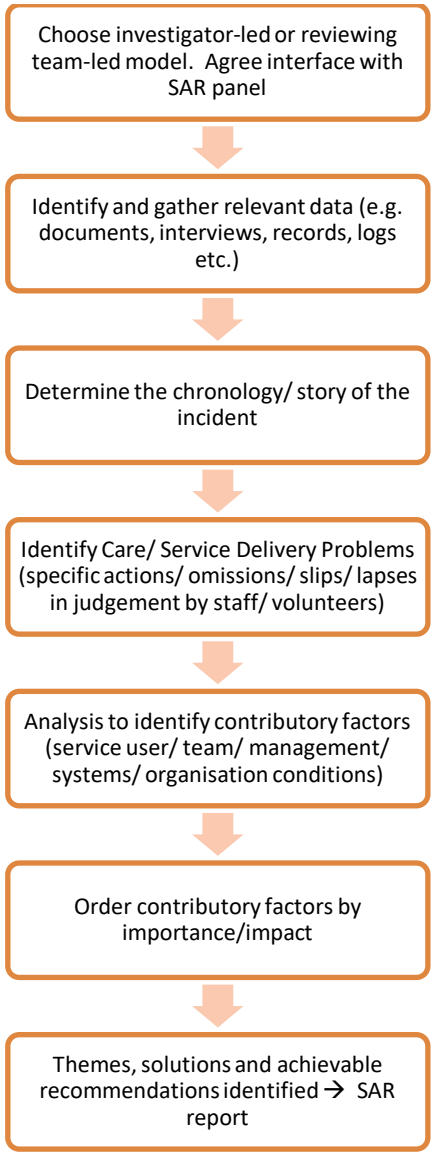
6.4 Regardless of the methodology selected, all SARs should be completed within six months unless there are extenuating circumstances. SAR panel members should try to agree an appropriate timescale for the review at the outset

6.5 A SAR In Rapid Time aims to have a turnaround time of 15 working days from set-up meeting, held after the decision has been made to progress with a review. Standardised processes and templates support this speedy turnaround.

**Fig. 1: SAR methodology decision tree:**



## Option A: Systems Analysis




### Key features:

- ✓ Team/ investigator led
- ✓ Staff/ adult/ family involved via interviews
- ✓ No single agency management reports
- ✓ Integrated chronology
- ✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change

### Advantages:

- Structured process of reflection
- Reduced burden on individual agencies to produce management reports
- Analysis from a team of reviewers may provide more balanced view
- Managed approach to staff involvement may fit well where criminal proceedings are ongoing
- Enables identification of multiple causes/ contributory factors and multiple causes
- Range of pre-existing analysis tools available
- Focusses on areas with greatest potential to cause future incidents
- Based on thorough academic research and review
- RCA* tried and tested in healthcare and familiar to health sector SAB members.

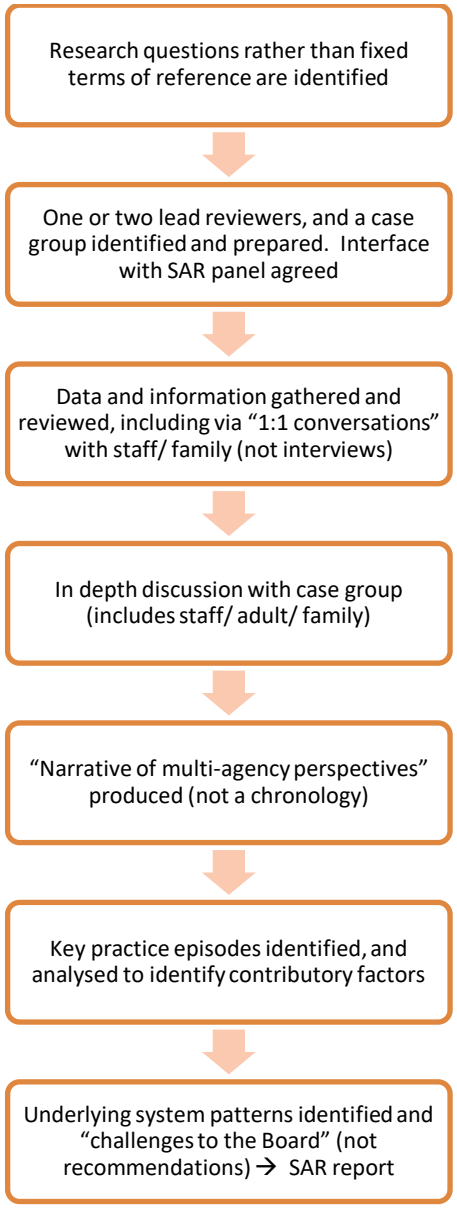
### Disadvantages

- Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
- Staff/family involvement limited to contributing data, not to analysis
- Potential for data inconsistency/ conflict, with no formal channel for clarification
- Unfamiliar process to most SAB members
- Trained reviewers not widely available
- Structured process may mean it's not light-touch
- RCA* may be more suited to single events/incidents and not complex multi-agency issues

### Available models:

Vincent et. al. (2003) Systems analysis of clinical incidents: the London Protocol
Woloshynowych et. al. (2005) Investigation and analysis of critical incidents
NHS National Patient Safety Agency (NPSA)* Root Cause Analysis

## Option B: Learning Together




### Key features:

- ✓ Lead reviewer led, with case group
- ✓ Staff/ adult/ family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; no chronology
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

### Advantages:

- Structured process of reflection
- Reduced burden on individual agencies to produce management reports
- Analysis from a team of reviewers and case group may provide more balanced view
- Staff and volunteers participate fully in case group to provide information and test findings
- Enables identification of multiple causes/ contributory factors and multiple causes
- Tried and tested in children's safeguarding
- Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity
- Range of pre-existing analysis tools available

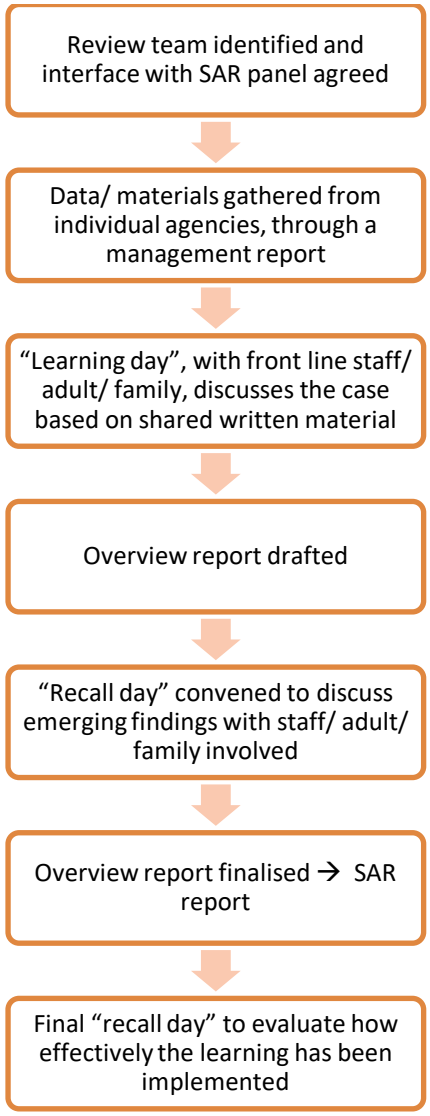
### Disadvantages

- Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
- Challenge of managing the process with large numbers of professionals/ family involved
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses
- Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR
- Opportunity costs of professionals spending large amounts of time in meetings
- Unfamiliar process to most SAB members
- Structured process may mean it is not light-touch

### Available models:

SCIE, Learning Together

## Option C: Significant Incident Learning Process




### Key features:

- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

### Advantages:

- Flexible process of reflection – may offer more scope for taking a light-touch approach
- Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants
- Has similarities to traditional SCR approach, so more familiar to most SAB members
- Agency management reports may better support single agency ownership of learning/ actions
- Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity

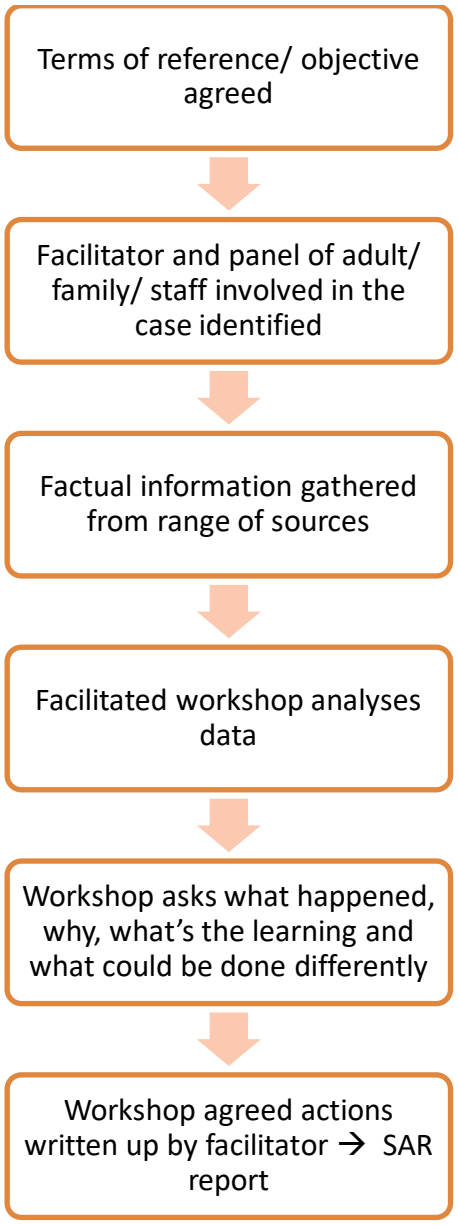
### Disadvantages

- Burden on individual agencies to produce management reports
- Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR
- Opportunity costs of professionals spending large amounts of time in learning days
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses
- Not been widely tried or tested, nor gone through thorough academic research/ review

### Available models:

Tudor, Significant Incident Learning Process

## Option D: Significant Event Analysis




### Key features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/ adult/ family involved via panel
- ✓ No chronology
- ✓ No single agency management reports
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourage reflection and change.

### Advantages:

- Light-touch and cost-effective approach
- Yields learning quickly
- Full contribution of learning from staff involved in the case
- Shared ownership of learning
- Reduced burden on individual agencies to produce management reports
- May suit less complex or high-profile cases
- Trained reviewers not required
- Familiar to health colleagues

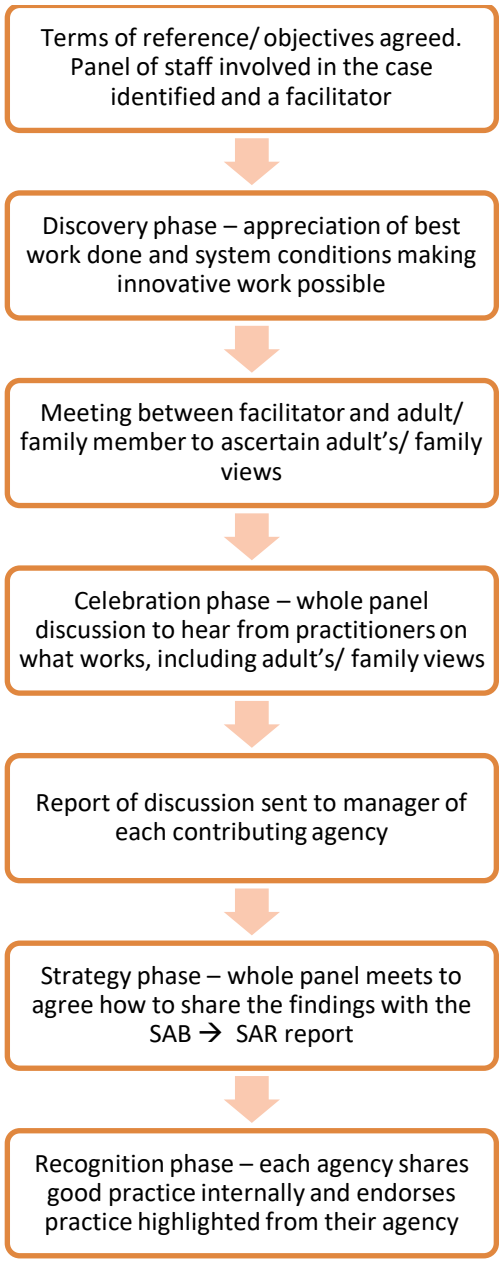
### Disadvantages

- Not designed to cope with complex cases
- Lack of independent review team may undermine transparency/ legitimacy
- Speed of review may reduce opportunities for consideration
- Not designed to involve the family
- Staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses

### Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis
Care Quality Commission, Significant Event Analysis
Royal College of General Practitioners, Significant Event Audit

## Option E: Appreciative Inquiry




### Key features:

- ✓ Panel led, with facilitator
- ✓ Staff involved via panel. Adult/ family involved via meeting
- ✓ No chronology/ management reports
- ✓ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

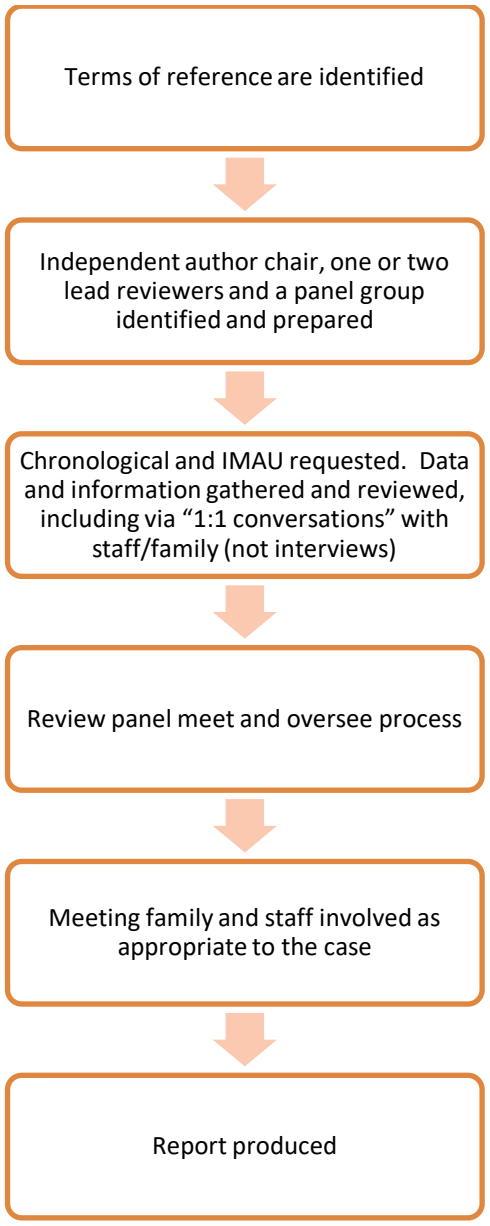
### Advantages:

- Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days
- Staff who worked on the case are fully involved
- Shared ownership of learning
- Effective model for good practice cases
- Some trained facilitators available
- Well-researched and reviewed academic model
- Model understood fairly widely

### Disadvantages

- Not designed to cope with 'poor' practice/ systems 'failure' cases
- Adult/ family only involved via a meeting
- Speed of review may reduce opportunities for consideration
- Model not well developed or tested in safeguarding. Minimal guidance available

## Option F: Safeguarding Adults Review: Traditional Methodology




### Key features:

- ✓ Panel led with independent author/chair
- ✓ Staff/adult/family involved via case group and 1:1 conversations
- ✓ Single agency management reports
- ✓ Single agency, no chronologies, then considered
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions

### Advantages:

- Structured process of reflection
- Analysis from a panel and may provide more balanced view
- Staff and volunteers participate fully in case group to provide information and test findings
- Enables identification of multiple causes/ contributory factors and multiple causes
- Familiar process to most SAB members and wider partners
- Range of pre-existing analysis tools available
- Applicable if the case also meets the criteria for a Domestic Homicide Review

### Disadvantages

- Burden on individual agencies to produce management reports
- Challenge of managing the process with large numbers of professionals/family involved
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses
- Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR
- Opportunity costs of professionals spending large amounts of time in meetings
  Structured process means it is not light-touch

### Available models:

SCIE, Learning Together

## 7. CONDUCTING THE SAFEGUARDING ADULTS REVIEW

7.1 If the SAR request is agreed, the Safeguarding Partnership Manager will commission the preferred candidate(s) to chair the SAR panel, and brief them on the agreed methodology, terms of reference and required timescales.

7.2 A multi-agency SAR Panel will be set up in line with the methodology and any requirements set by the Standing Subgroup Chair.

7.3 The Safeguarding Partnership Team, in supporting the SAR panel chair will:

- Set SAR panel meeting dates and agendas as required.
- Invite all nominated representatives from relevant agencies to SAR panel meetings.
- Notify Kirklees SAB of any administrative/resourcing arrangements that are missing.
- Liaise with the police and/ or coroner's office as required.
- Arrange early discussions with the adult(s) and their family/ representatives and arrange any support they require to participate.
- Initiate the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice.
- Request any data/evidence/reports from partner agencies as required.

## 8. ADULT/ FAMILY INVOLVEMENT AND INDEPENDENT ADVOCACY

8.1 This section must be read in conjunction with Section 68 of the Care Act and associated statutory guidance, and in conjunction with SAR Quality Marker 3.

8.2 Adults and/ or families should be invited and supported to contribute to SARs[5] if they wish to do so, so that their wishes, feelings, and needs are placed at the heart of the review.

8.3 The SAR Panel Chair/SAB Manager must attempt to make contact with the adult (s), their family and/ or representatives early on 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.

8.4 Reasonable and appropriate support and adjustments should be made by Kirklees SAB 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.

[5] Care Act statutory guidance paragraph 14.136

- Access to an interpreter.
- Support from a chosen chaperone or representative.
- Longer meeting times
- Pre-meeting briefings and post-meeting de-briefs.
- Access to an independent advocate.

8.5 If there is no appropriate person to support and represent the adult(s), then Kirklees Council must arrange for an independent advocate (under Section 68 of the Care Act). Arrangements should be made in line with Kirklees Council's standard policy and procedures for arranging advocacy.

8.6 Alternatively, if the relevant criteria are met, appropriate partners can arrangements for an independent mental capacity advocate (IMCA) or an independent mental health advocate (IMHA) to support and represent the adult(s). If an independent advocate, IMCA or IMHA has already been arranged for the adult (s), e.g., during assessment and care support planning or for a safeguarding enquiry, then the same advocate should continue to be used.

8.7 It is for the SAR panel to form a judgement on a case by case basis about whether the adult(s) has "substantial difficulty" in being involved in the SAR process[6] and about who can act as an appropriate person.[7]

## 9. STAFF INVOLVEMENT

9.1 As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case 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, volunteers, and their line managers. It should be made clear that the review process can be lengthy.

9.2 It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so that real learning and improvement can happen.

9.3 Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offered support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

## 10. PROFESSIONAL CONDUCT ISSUES ARISING

10.1 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 and volunteers. Issues of professional conduct may become apparent during a SAR, and there are separate formal processes to address these. It is not

[6] Care Act statutory guidance paragraph 7.9

[7] Care Act statutory guidance paragraph 7.40

within the SAR remit to deal with these. (SAR Quality Markers 4)

10.2 Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

## 11. SAR REPORTS

11.1 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 as agreed by the SAR standing Subgroup. It is anticipated that for statutory SARs and some discretionary SARs a short report will be required.

11.2 The SAR panel chair must ensure that there is sufficient 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.

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

11.4 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.

11.5 Kirklees SAB 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 could include publication via the Kirklees SAB webpages. Any reports to be published must be fully anonymised.

11.6 The chair of Kirklees SAB 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 Kirklees SAB's information sharing agreement, the Data Protection Act and other legal requirements.

## 12. QUALITY ASSURANCE OF THE SAR

12.1 Quality assurance is embedded throughout the SAR process, from commissioning through to SAB scrutiny of the report and implementation of recommendations. Quality assurance is also built into the SAR methodology options set out in this framework.

12.2 In each model it is imperative that SAR panel members avoid agency defensiveness and arguments about minute detail of what happened. The following arrangements will help to avoid/ minimise this:

- Commissioning the most appropriate SAR methodology for the case
- Commissioning a suitably skilled, experienced and independent SAR lead or chair to facilitate the review and analysis.
- Independence of SAR panel members from the case under review.

- A focus in each model on seeking out causal factors and systems learning.
- Requirements in the terms of reference for the SAR to take a broad learning approach and to "tell it like it is".

12.3 Finally, the contents of the report presented to the SAB must contain enough of the methodology for the SAB to be able to check, scrutinise and challenge. In doing so, the SAB will gain assurance of the adequacy of the evidence, quality of the analysis and usefulness of the recommendations, but will not duplicate the work already completed in the course of the SAR.
(See SAR Quality Markers 12)

## 13. ACTING ON THE RECOMMENDATIONS OF THE SAR

13.1 Kirklees SAB 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 SAB may decide not to implement a recommendation(s),

13.2 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 improvement
- The processes for dissemination of the SAR report or its key findings.

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

13.4 Board members of Kirklees SAB 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.

13.5 Kirklees SAB will monitor progress on all recommendations (or delegate to an appropriate Subgroup) and may commission specific pieces of work to measure the impact. It may also request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

13.6 In line with Schedule 2 of the Care Act, Kirklees SAB will include findings from any SARs in its annual report, and information on any ongoing SARs.

## 14. APPLYING LEARNING FROM OTHER SARs

14.1 Kirklees SAB is committed to the regular analysis of the themes and learning from nationally high-profile SARs and relevant other SARs as selected by the Standing SAR Subgroup.

14.2 The Standing Subgroup has a process for the review of SARs from outside Kirklees as part of their annual workplan to ensure lessons are identified, disseminated, and embedded:

- The Safeguarding Partnership Team identifies key themes and learning from SARs outside of Kirklees, and presents findings from a case to the Subgroup
- The Subgroup reviews the themes and learning in the Kirklees context to evaluate learning and identify any areas of improvement for Kirklees.
- The learning is disseminated to partners via their Subgroup members for discussion and implementation of any single agency learning.it is also shared via the Learning Subgroup and Quality and Performance Subgroup as appropriate
- Relevant multi-agency learning, and actions identified will be drawn together and presented to the SAB annually for discussion and consideration as part of the SAB strategic plan.

14.3 The Standing Subgroup will do whatever else seems reasonable to facilitate the dissemination and embedding of this learning into practice, for instance, facilitating a learning slot at a SAB meeting or away day, circulating e- newsletters, incorporating findings into training and workshops for staff etc.

## 15. SUPPORTING AND RESOURCING SARs

15.1 Section 44(5) of the Care Act requires each member of Kirklees SAB 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.

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

*"cooperate 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."*

*"cooperate when requested in relating to specific cases, such as SARs".*

15.3 In addition, Section 45 of the Care Act places a duty on all partner organisations to supply information to Kirklees SAB (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.

15.4 Resources are needed for undertaking and supporting a SAR. The statutory partners on the Kirklees SAB 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

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

15.6 The Safeguarding Partnership Team will maintain an annual overview of SAR related costs for the SAB, for consideration each year as part of the annual report and to aid annual budgeting by partner organisations.

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**[END]**

## Appendix 1: Flowchart for request of a SAR from Kirklees SAB

**Initial SAR Request**

- Contact ksab@kirklees.gov.uk to ask for a Safeguarding Adults Review (SAR) request form
- Completed SAR request form is emailed securely to KSAB@kirklees.gov.uk
- Confirmation of receipt of the request is sent by email to the requestor

**Request Received**

- On receiving a SAR request, the Chair of the SAR Subgroup and SAB Manager will meet to decide whether the criteria for a SAR have been met

**Initial Scoping Process**

- Relevant scoping documents are sent out to all agencies advising of the required return date and informs the referrer that scoping is taking place
- All documents are returned securely and are shared with the SAR Subgroup 2 weeks prior to meeting

**SAR subgroup decision**

- Once the information is received the Standing Subgroup meets to finalise decision making, in line with the SAR criteria and deciding which methodology to use (see section 5 and section 6).

**Final Decision**

- The Independent Chair of the SAB will ratify the decision of the Standing Subgroup and 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) are to make the necessary arrangements for participation in the SAR, e.g. immediate securing of files and records; nominating a representative for a SAR panel etc. The Chair of Kirklees SAB will also arrange for relevant commissioning and regulatory bodies to be notified that a SAR has been initiated.

- Where the requestor is dissatisfied with this outcome, they should notify the Chair of Kirklees SAB in writing, who will discuss and review (if necessary) the decision with the requestor and the Standing Subgroup.

- The Chair will then arrange for a review of the request with requestor and Standing SAR Subgroup

## Appendix 2: Acknowledgements

Kirklees SAB would like to acknowledge the use of the following sources in the development of this SAR framework:


ADASS (2013), Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services**.**

Bestjan, S. (2012) S**erious safeguarding adults reviews: guidance note on options for London.**

Bowie, P., and Pringle, M., (2008), **Significant Event Audit: Guidance for Primary Care Teams**, (National Patient Safety Agency).

Department of Health (2014), Care and Support Statutory Guidance: Issued under the Care Act 2014

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SCIE (2015), Safeguarding Adults Reviews under the Care Act: implementation support **and** Safeguarding Adult Review Quality Markers (March 2022)

UK Parliament (2014), Care Act 2014**.**

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