Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Safeguarding Adults Board LEICESTERSHIRE & RUTLAND

Safeguarding Adults Reviews

Guidance for Staff and Managers

Leicester, Leicestershire and Rutland Safeguarding Adults Boards

Introduction

Safeguarding Adults Reviews

The death or serious injury to an adult is a distressing event for everyone, and, when this then leads to inquiries being made about the work of professionals who were providing services to the adult, with family/carers involved, it can lead to staff/professionals feeling very anxious. This anxiety can become a barrier for learning and impact on staff morale.

That is why it is important that all staff involved in the process of a **Safeguarding Adults Review** into the death or serious injury of an adult have a clear understanding of why the review is happening, what it expects to achieve, what it involves, what is expected of them and what the timeframe is.

The Care Act 2014 outlines a Safeguarding Adults Board's core duty to conduct safeguarding adults reviews in accordance with Section 44 of the Act, which can be found here: https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect

(1) An 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.

(2) Condition 1 is met if—

(a) the adult has 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).

(3) 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.

(4) An 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).

Background to a Safeguarding Adults Review

Staff support

Support for staff involved is an integral and central part of the process.

It is recognised that involvement in a Case Review can be a very difficult and stressful experience. It is important that staff involved in the review process are kept informed about the progress of the review and the timescales involved.

Our approach depends on a clear commitment to learning and taking a whole system approach so that we focus on how our systems support good practice rather than looking for individual failure. We want to recognise good practice when this is seen and learn when things could be done better.

At the start of any Case Review process, management within each agency will take the lead for supporting the staff who are currently involved in the case and will identify a single point of contact who can provide a direct line of communication throughout the learning process. Other staff who may have been involved at other stages of intervention, including in the past, will be identified and included in any support that is provided.

The Business Offices for the Leicester, Leicestershire & Rutland Safeguarding Adults Boards (SAB) will assist in the process by liaising with nominated individuals to offer support and advice.

Staff with any concerns should discuss these with their line manager.

Why are we having a case review?

A review is not about looking for blame, but about open and transparent learning from practice, to improve multi-agency working and outcomes for adults.

We want to learn lessons about how we provide services and work together, so that we can continue to improve our safeguarding practice and the way we work with adults with care and support needs. We do this by drawing together all the information about the case; looking at how the events and relationships, both within the family/support network and within the professional network, can be understood and identifying the lessons that can be learned from the case. This aims to inform and improve professional practice in the future.

It will also include identifying how these lessons can be acted upon and what is expected to change as a result. This may mean reviewing processes and procedures and providing training.

It is recognised that this learning takes place in a context where some staff involved may be experiencing high levels of distress and anxiety.

The objective is to conduct a review that both acknowledges the importance of professional accountability and retains its sensitivity to the needs and feelings of the individuals most directly involved.

The Scope of the Safeguarding Adults Review

What does the review involve?

There are several stages in this process:

Referral to the Safeguarding Adults Board

Any agency can make a referral for a SAR where it is believed that it meets the criteria. Referrals should be made via the organisation's safeguarding lead

Decision making

The referral is heard at a meeting of the SAB Review Subgroup/Case Review Group. Members of the group will have checked if the person(s) is known to their agency prior to the meeting to support effective decision making.

After the SAR referral has been heard, the Review Subgroup may decide that further information is required to support the decision-making process. Where this is required, the request for further information is made and a response time is agreed by the Group. The request for further information needs to clearly set out the information needed to make a decision e.g. based upon the SAR criteria.

Having considered the SAR referral, legal advice and, where relevant, the additional information provided, it will be the responsibility of the Review Group to make a recommendation to the SAB Independent Chair about whether to commission a safeguarding adults review and the scope of this. The SAB Independent Chair will notify the SAB Review Subgroup/Case Review Group of their decision.

All agencies must secure records and files in relation to the case to ensure they are only accessed by nominated personnel as necessary.

Initial learning

Initial findings focused on learning will be fed back to the Senior management team so that any actions for single agency learning can be agreed and to confirm how staff will be supported in the review period. This includes endorsing the nominated Single Point of Contact for staff involved. This person will provide a crucial link for staff to keep them up to date with progress and to answer any questions.

Terms of Reference for the review will be agreed, which will include the time period covered by the review and key lines of enquiry for learning identified in the Review.

SAR Methodology

SARs may be carried out using a variety of methods, for example Case Audit, Appreciative Inquiry. The following is an outline of one of the most common approaches and incorporates many of the elements found in other methods.

The Scope of the Safeguarding Adults Review

What does the review involve?

Identification of the single agency IMR author - Authors from each agency are usually identified to write internal reports called 'IMRs' or Individual Management Reports. The author for your service will want to speak to you to obtain your views about the case. They will seek to identify good practice and identify learning. Staff can also raise areas they wish to bring to the author's attention.

Authors will feed back to staff their findings and recommendations. It is important that agencies start to implement the learning from their author's reports immediately it is available

Forming a case review Panel - A case review panel is usually formed to consider the single agency reports and to develop a multi-agency perspective. Members of the panel are made up from relevant safeguarding representatives from each agency involved with the adult leading up to the serious incident.

An **Independent Author** is often commissioned to write an **Overview Report**. The author will have specialist skills and knowledge and be independent of the agencies involved. The completed IMRs are given to the SAR Panel and the independent author, who uses them and any further inquiries they decide to make, to produce a report. They will identify key learning and may make recommendations for improvement.

Practitioners Events may be held in some cases to allow staff to talk about the case freely, to identify key learning and good practice in a confidential environment.

Will I be interviewed? The Independent Author may request permission to interview key people who have been professionally involved with the adult in the case. These interviews would only take place with the permission and support of your manager.

Timescales

A case review should be completed and published within 6 months if possible however there can be many reasons for delay. This includes when criminal proceedings are taking place.

Publication and Parallel Processes

Publication

Is the report available to the general public?

The purpose of the SAR is to identify learning to improve systems and services, in order to share this learning widely and for transparency the SABs will look to publish all local SARs except in exceptional circumstances.

All internal (IMR) reports have to be anonymised. The identity of staff is only known by the case review panel, the IMR authors and the overview report authors. These documents are not made public.

The Overview Report is confidential to the case review panel. The panel can choose how widely it shares it with senior managers in partner agencies to support them improving practice through learning lessons. This *may* be published in full but would be heavily anonymised to prevent the persons involved being identified.

An anonymised Executive Summary is often produced which *may* be published to share identified learning and good practice.

Before publication, a meeting should be held with any staff directly involved so that they are aware of what is being published and when and there is usually a learning workshop to share the key findings.

Themes of learning emerging from any case reviews are gathered routinely and form part of our Quality Assurance work.

Parallel Processes

Some members of staff may be involved in parallel processes. This could include providing information or evidence to aid a criminal investigation by the police or a Coroner's Investigation in preparation for an Inquest if someone has died.

If there is a police investigation am I still allowed to talk about it?

If there is a police investigation it may mean discussion of the actual incident and/or run up to the incident is not appropriate or permitted. It is important to note that a police investigation is a moving process and it may be at one point in time staff are advised not to discuss the case amongst themselves but at a later date this advice might change.

It is therefore important to check throughout the process and seek advice from your manager or the Safeguarding Board Office.

Parallel Processes and Guidance for Managers

How does the review relate to disciplinary action?

The case review process is not a way to blame or punish staff and is separate to any decision to initiate other single agency procedures.

On some occasions if specific concerns are identified for example if procedures have not been followed it is possible that internal disciplinary processes are applied. These are confidential to the individuals and their agency and kept separate from the case review. Each agency has their own disciplinary process. Separate support within that process will be made available including if required, access to union and HR support. The reason for any use of disciplinary or capability procedures must be made explicit to the member of staff and requires careful application of the procedures which are available on the intranet

Guidance for Managers

Senior Managers should encourage staff to seek support and guidance from line managers including front line manager. For managers with a case in their team they should encourage team discussion to provide support, but this meeting should be an opportunity for staff to talk about how they are feeling and what support they need, it should not be a discussion about who did what, when etc.

If managers have any queries or concerns, please contact the Safeguarding Board Office managing the review.