Somerset Safeguarding Adults Board Safeguarding Adults Reviews

Introduction

A vital role of a Safeguarding Adults Board is to seek assurance on the effectiveness of local safeguarding activity and ensure safeguarding practice is continuously improving and enhancing the quality of life for adults with care and support needs and carers in line with the principles of 'Making Safeguarding Personal'.

The Care Act 2014 introduced Safeguarding Adults Reviews (SARs) – previously known as Serious Case Reviews. Their main function is to identify whether lessons can be learnt about the effectiveness of professionals and agencies working together to safeguard adults at risk.

What are the criteria for a SAR?

Safeguarding Adults Boards must arrange a SAR when:

- An adult[1] in its area dies 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 in its area has not died, but the Board knows or suspects that the adult has experienced serious[2] abuse or neglect.

Boards may also commission a SAR in other circumstances where it feels it would be useful, including learning from 'near misses' and situations where the arrangements worked especially well.

A SAR can be requested by any partner agency, the Coroner, or the Secretary of State.

What is the purpose of a SAR?

The purpose of a SAR is not to hold any individual or organisation to account – other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and existing systems of service and professional regulation.

Rather, SARs seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so lessons can be learnt from the case, and those lessons applied in practice to prevent similar harm occurring in the future.

How are SARs conducted?

The Care Act gives Safeguarding Adults Boards flexibility to choose a proportionate methodology for SARs in recognition that no one model will be applicable for all cases. The process for undertaking SARs should be determined locally according to the specific circumstances of the case. The Board will need to weigh up what type of review process is proportionate to the case and which will promote effective learning and improvements in practice. 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 been seriously abused or neglected.

There are a variety of methodologies that can be adopted. The traditional approach has been to appoint a SCR panel and Chair (usually independent) which determines the terms of reference for the review and oversees the process. Involved agencies prepare detailed

[1] Adult must be in the SAB's area and have needs for care and support, whether or not the local authority has been meeting any of those needs

[2] Serious abuse or neglect occurs when, 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 (whether because of physical or psychological effects) as a result of the abuse or neglect

chronologies of events and produce Individual Management Reports (IMRs) which outline agency involvement against the aspects identified within the terms of reference. An overview report is then prepared with analysis, lessons learnt and recommendations. Relevant agencies produce action plans in response to the lessons learnt, and the Safeguarding Adults Board monitors implementation across the partnership.

The ultimate decision to arrange a SAR is the responsibility of the Independent Chair of the Board.

Are SARs published?

The Care Act 2014 requires Safeguarding Adults Boards to publish an Annual Report. The findings of any SARs completed during the year, or details of any ongoing SARs, should be referenced within the Report, as should detail relating to what has been done to implement the findings of the review or the reasons for deciding not to implement the findings of the any review.

It is not a statutory requirement to publish reports or executive summaries (and issues of consent and confidentiality will need to be considered); however, it is recognised good practice to demonstrate the level of transparency and accountability needed to enable lessons to be learned as widely and thoroughly as possible. This should ensure professionals are able to understand what happened and, crucially, what needs to change in order to reduce the risk of similar tragic events happening in the future.

How are lessons learnt following a SAR?

Routes for dissemination of learning include:

- Single and multi-agency training
- Board development days / conferences
- Local forums and networks
- Board publications and briefings

Activities to enable embedding learning into practice include:

- Policy, procedure and practice guidance development
- Effective use of reflective practice and supervision
- Team/staff meetings.