Safeguarding Adult Review

Notification of a Safeguarding Adult Review

Guidance for Professionals

Version Control

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Safeguarding Adult Review Guidance

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1.0 Introduction

1.1 The prime purpose of a Safeguarding Adult Review is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of adults with care and support needs.

1.2 The statutory guidance on Safeguarding Adult Review is set out in *Chapter 14 of The Care Act Statutory Guidance 2014,* and taken forward by West Midlands Adult Safeguarding Policies and Procedures 2015.

1.3 **Criteria**

Safeguarding Adults Boards must arrange a SAR when:

- An adult* 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*.

They must 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.

They 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.

* Adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** Something can 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 (whether because of physical or psychological effects) as a result of the abuse or neglect.

1.4 The purpose of this guidance is to provide individuals and organisations with a local framework for the initiating and conducting of Safeguarding Adult Reviews; and a range of good practice tools and exemplars for those involved in managing the process to ensure reviews are carried out effectively and in a consistent manner. The documents that support this guidance are:

a) Information for individuals and families
b) WSAB Administrators Toolkit
c) Safeguarding Adult Review Committee Toolkit
d) Safeguarding Adult Review Panel Toolkit
e) Internal Management Review Toolkit
f) Information for staff

2.0 Principles for Learning and Improvement

2.1 Safeguarding Adult Reviews and other case reviews should be conducted in a way which:

a) Recognises the complex circumstances in which professionals work together to safeguard adults with care and support needs.

b) Seeks to understand precisely who did what and the underlying reasons that led to individuals and organisations acting as they did;

c) Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

d) Is transparent about the way data is collected and analysed; and

e) Makes use of relevant research and case evidence to inform the findings.

2.2 Families, individuals; and significant others should, whenever possible, be invited to contribute to reviews. They should be supported to understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Involvement of the individual and family provides the opportunity to[1]:

a) obtain a person perspective: provides professionals with the opportunity to understand the adults lived experience and a sense of the adults personality and identity;

b) obtain an insight into family life and professional encounters: family narratives about services is unique and dynamic; and minimises assumptions being made solely on case records or agency records;

c) Assist the individual and family members (individually and collectively) to cope with their feelings and the aftermath of an adult dying or suffering a serious injury.

2.3 There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of adults; that identifies opportunities to draw upon what works and to promote good practice. Where areas for improvement have been identified, this must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for adults.

2.4 The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in adults being protected from suffering or being likely to suffer abuse or neglect in the future. It is essential to maximise the quality of learning, ensuring that the adult's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the

[1] A study of family involvement in Case Reviews, BAPSCAN, 2012

centre of a Safeguarding Adult Review, irrespective of whether the adult died or was seriously injured.

3.0 Safeguarding other adults

3.1 When an adult dies or is seriously harmed, and abuse and/or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other adults who are suffering, or likely to suffer significant harm and who require safeguarding (for example, other adults in an institution where abuse is alleged).

3.2 Where there are concerns about the welfare of other adults the guidance in the West Midlands Adult Safeguarding Policy and Procedure must be followed to raise a safeguarding referral.

3.3 When an adult with care and support needs dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the death, the SAB should always conduct a SAR into the involvement of organisations and professionals in the lives of the adult and family. This is irrespective of whether local authority adult social care is, or has been, involved with the adult.

3.4 If a member of staff of any agency feels that a case may meet the criteria for a Safeguarding Adult Review, they are encouraged to discuss this with the Senior Named Officer for Adult Safeguarding within their own organisation; who may in turn wish to discuss the concerns with the Head of Safeguarding.

3.5 On receipt of a SAR referral, Wolverhampton Safeguarding Adult Board at the next scheduled meeting will consider the case within one month.

The Referral Form should:

a) Outline the details of the case;
b) The reasons for the referral; and
c) The criteria set out in *The Care Act 2014 Statutory Guidance* that applies to the case.

3.6 The recommendations of the Safeguarding Adult Review Committee, whether to commission a Safeguarding Adult Review, or not, and the reasons for the recommendation will then be considered by the Independent Chair of the WSAB, who make's the final decision. (See Appendix 1: Notification Flowchart)

3.7 Further information about how Safeguarding Adult Reviews are initiated and managed can be found in the toolkits that accompany this guidance.

4.0 Timescale for completion of a Safeguarding Adult Review

4.1 Safeguarding Adult Reviews, wherever possible, should be concluded within 6 months.

5.0 Publication

5.1 The Care Act 2014 places a duty on Safeguarding Adult Boards to publish in its annual report the conclusions and recommendations of the SAR. The West Midlands Adult Safeguarding SAR Guidance requires WSAB to publish anonymised Overview Reports and Executive Summaries.

5.2 *The West Midlands Adult Safeguarding SAR Guidance* makes clear that it is only by publishing SAR reports that organisations will demonstrate to the public 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 fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Notification of a Safeguarding Adult Review Flowchart