**Guidance for multi-agency Safeguarding Adults Board and the SAR Evaluation Group**



**June 2019**

**To be reviewed June 2020**

**Guidance for Multi-Agency SAR Evaluation Group**

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**Safeguarding Adults Board**

**Guidance for multi-agency SAR Evaluation Group**

***Context***

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They will make sure that Safeguarding Adults Boards (SABs) get the full picture of what went wrong, so that all organisations involved can improve their practice.

In developing these guiding principles, the Merton Safeguarding Adults Board seek to ensure that:

* We have processes for leaning and reviewing that are flexible and proportionate and open to professional and public challenge.
* We can determine locally what type of review is appropriate dependent on the nature of the case and the agencies involved.
* A culture of transparency is created that provides for a positive shared learning culture.
* All partners are clear on the accountability under the statutory role of the Board to participate and provide information when the decision to undertake a review has been made

This document sets out the Boards’ expectations for a Safeguarding Adult Review of a serious case, within which there is room for professional judgement and flexibility.

***Legislation***

Section 44 of the Care Act puts a duty upon the Safeguarding Adults Board (SAB) to

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:

* There is reasonable cause for concern about how the SAB, its members of other persons with relevant functions worked together to safeguard the adult,

and

* The adult has died, and 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).

Or

* If the adult is still alive, the SAB knows or suspects that the adult has experienced serious abuse of neglect.

Under the Care Act each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to identifying the lessons to be learnt from the adults case, and applying those lessons to future cases.

***Circumstances to consider a multi-agency response***

The board may also conduct a review in other circumstances, for instance:

* In circumstances involving the abuse and neglect of a large number of adults at risk or by multiple perpetrators. With regard to institutional abuse there must be clear evidence that standard of care are so low that all, or the majority, of service users are at risk.
* Where a case gives rise to concerns about the way in which local professionals and services work together to safeguard adults at risk.
* Any case where there are public interest issues and where the SAB agrees there is a specific need to carry out a review.

***Guiding principles***

The following principles should be observed. The degree of relevance will depend upon the nature of the case and type of review:

1. **Urgency** – agencies should take action immediately and follow this through as quickly as possible.
2. **Accountability and engagement** – the SAB will hold individual agencies to account at each stage of the process.
3. **Impartiality** – those conducting reviews should not have been directly concerned with the adult at risk of the family.
4. **Thoroughness** – all important factors should be considered and there should be an opportunity for all those involved to contribute.
5. **Inclusion** – the review should include, and support, the victim, family and staff throughout the process as appropriate.
6. **Links** – should be made to other investigations and the criminal justice system.
7. **Openness** – the review should be a transparent and honest appraisal of practice. Publication will be considered on a case by case basis.
8. **Confidentiality** – the review will operate within a framework of confidentiality, paying due regard to the balance of individuals’ rights and the public interest.
9. **Co-operation** – each SAB should provide a framework to ensure close collaboration between all the agencies involved.
10. **Resolution and learning** – any new knowledge or lessons learned should be shared and disseminated on a multi-agency basis, with identified issues promptly actioned by the agencies concerned. Additionally it is intended that they will be used to develop and promote practice regionally.
11. **Review** – action should be taken to ensure recommendations have been implemented.

***Decision making process***

The MSAB will have its own decision making processes for such reviews but it is expected that all Boards will ensure that decisions are made as expeditiously as possible.

There should be clarity about what is expected from the review, where the best learning will be and what type of review will be most useful.

If it is not clear whether the case reaches the criteria for a SAR, managers may have a multi-agency triaging review to support the decision making process.

One recommended approach is that a scoping report to be sent to the Chair of the Board. The Chair will then discuss with the relevant colleagues/professionals the most appropriate course of action to take. The group should consider which type of review will offer the most significant new leaning and is most appropriate for the agencies involved. This information will be circulated to relevant Board members for comment. Discussion should include consideration of required resources.

The decision making approach should be transparent and should involve partner agencies. Decisions should be carefully recorded and signed off at an appropriate level.

Those conducting a review should be of an appropriate senior level in the organisation, and be able to remain objective and impartial.

***Supply of information***

It is important that organisations share information related to abuse or neglect with SARs.

The Care Act is clear that if a SAB requests information from an organisation or individual who is likely to have information which is relevant to SAB’s functions, they must share what they know with the SAB. This is so any problems can be tackled quickly, and lessons can be learnt to prevent the same thing happening again.

Consideration should be given by those conducting a review to attend a Coroner’s inquest.

***Support for the adult at risk***

All processes should engage service users and their carers and take into account their wishes.

If the adult at risk has capacity they will be invited to contribute to the review. It is important to support them to contribute their views if they wish. They should be informed of the review and any findings shared with them.

The adult at risk may need a worker and/or advocate supporting them throughout the process and will need further contact as appropriate. This will include informing them of the review and sharing the findings.

***Support for the family***

If the adult at risk has capacity and gives consent for their family and others who have significant involvement in their lives to be involved with the review, then the family will be invited to contribute.

It is important to support members of the family to contribute their views if they wish.

This is an inclusive process and support, including access to professional interpreters and accessible communication means, should be provided to overcome any communication barriers. The family may need a worker to support them through the process and will need further contact as appropriate. They should be informed of the review and any findings shared with them.

At the end of the process they should be given the opportunity to discuss the outcomes and their experience of the process, for example through a case conference.

***Involving staff throughout the process***

As soon as a SAR has been agreed, staff that have had involvement 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 and their line managers. It should be made clear that the review process can be lengthy. Is it important that all relevant members of agencies are interviewed and given an opportunity to share their views on the case.

Agencies are responsible for ensuring staff are provided with emotional support. This support should be clearly identified and communicated to all staff involved. The death or serious injury of an adult at risk will have an impact on staff and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff involved to the team, organisation or workplace.

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. However, on occasion, concerns about an individuals practice may be raised through the review process and these concerns would be fed back to their agency through the SAR Chair. Any action, including disciplinary action as a result of this, would remain the responsibility of the individual agency.

Professionals should be asked their views about what, in their opinion, could have made a difference for the adult or family.

***Accountability and engagement***

The Board will hold individual agencies to account at each stage of the process: engagement in the review, inform practice developments and other management processes where relevant, and monitor effectiveness of the changes.

In practice this means to committing to attending meetings, contributing to developing the findings, make the Board aware of progress on developing and delivering action plans.

If there are multi-agency findings from the review, they should be shared with the Board and partner agencies.

***Links with other investigations, the Criminal Justice System and Domestic Homicide Reviews***

SARs are not enquiries into why an adult dies or who is to blame. These are matters for the Coroner’s Court, Criminal Courts and employment procedures as appropriate. SARs are also not disciplinary proceedings and should therefore be conducted in a manner which facilitates learning. Appropriate arrangements must be made to support those staff involved.

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. There is an expectation that these will continue throughout the review process if any other issues are identified it is appropriate that these are dealt with.

The domestic homicide Review (DHR) process will be used when someone has been killed as a result of domestic violence and abuse. DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004).