West of Berkshire
Safeguarding Adults Board

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*Working Together*

# GUIDANCE FOR MULTI-AGENCY SAFEGUARDING ADULTS REVIEWS OF SERIOUS CASES

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***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 Berkshire Safeguarding Adults Boards seek to ensure that:

- We have processes for learning 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.

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:

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

and

II. 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

III. If the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or 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 adult's 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 standards 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 Safeguarding Adults Board 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:

a) **Urgency** – Agencies should take action immediately and follow this through as quickly as possible.

b) **Accountability and engagement** – the Board will hold individual agencies to account at each stage of the process.

c) **Impartiality** – Those conducting reviews should not have been directly concerned with the adult at risk or the family.

d) **Thoroughness** – All important factors should be considered and there should be an opportunity for all those involved to contribute.

e) **Inclusion** - The review should include, and support, the victim, family and staff throughout the process as appropriate.

f) **Links** - should be made to other investigations and the criminal justice system.

g) **Openness** – The review should be a transparent and honest appraisal of practice. Publication will be considered on a case by case basis.

h) **Confidentiality** – The review will operate within a framework of confidentiality, paying due regard to the balance of individuals' rights and the public interest.

i) **Co-operation** – Each Safeguarding Adults Board should provide a framework to ensure close collaboration between all the agencies involved.

j) **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.

k) **Review** – Action should be taken to ensure recommendations have been implemented.

***DECISION MAKING PROCESS***

Each Local Authority 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 be sent to the Chair of the Board. The Chair will then discuss with 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 learning 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 SABs.

The Care Bill 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 account of 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 to support 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. It is 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 individual's 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 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.

## *Interagency reviews need to be shared with all Berkshire Safeguarding Boards and other areas as appropriate.*

### *LINKS WITH OTHER INVESTIGATIONS, THE CRIMINAL JUSTICE SYSTEM and DOMESTIC HOMICIDE REVIEWS*

Safeguarding Adults Reviews 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 instead 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).

The **Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews** can be found at this link:
https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

***MULTI-AGENCY SAFEGUARDING ADULT REVIEW TOOLKIT***

Currently there is a proliferation of competing methodologies mainly developed for other purposes and now adapted for s reviews, and there is a possible danger of fitting the review to the methodology rather than the methodology to the review.

Below is an outline of some of the review methods available. Further information can be found by following the relevant links. This list is not exhaustive.

**1. Traditional Serious Case Review**

All the agencies involved contribute to the review. The Board will commission an Overview Report which brings together and analyses the findings of various reports from agencies in order to make recommendations for future action. An action plan is developed and the SAB and senior managers within relevant organisations make sure improvements are made. The report is written by an independent person.

http://berksadultsg.proceduresonline.com/chapters/p_ser_case_rev.html

**2. SCIE Learning Together Review**

Learning Together is based on a 'systems approach' which recognises that any worker's performance is a result both of their own skill and knowledge, and the systems (context) in which they work. It is a collaborative approach and appreciates the views of people from different agencies and professions.

It is a well developed, recognised and tested systems approach to learning and improvement, as recommended by the Munro Review of Child Protection (2011) and Working Together to Safeguard Children (2013).

A Learning Together review**:**

- focuses on the child or adult affected;
- engages all of the agencies involved in the case;
- goes beyond identifying what happened, to explaining *why* it happened;
- generates new ideas about how to improve practice; and
- develops local skills and expertise.

The process helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.

http://www.scie.org.uk/children/learningtogether/model.asp

**3. Significant Incident Learning Process (SILP)**

Developed by Paul Tudor, the SILP uses a similar approach to the SCIE Model. It is intended for reviewing cases which do not meet the criteria for traditional Serious Case Reviews, or for cases that meet the criteria, but would benefit from a more proportionate approach to obtain the best learning.

This approach encourages the engagement of frontline staff and first line managers in conjunction with Board Members and / or other relevant professionals. The involvement of

frontline staff and first line managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

Process:
The key agencies and professionals involved in the identified case will be invited to a half-day or full day event to examine the case together.

Rather than an IMR, agencies will provide chronologies of events, one facilitator will chair the event and another will write up the learning. An external facilitator may be used if the complexity of the case means it is necessary to do so.

This process will involve operational staff and their managers who would own their own summary of learning at the end of the process, leading to these being disseminated more quickly and at an operational level. A second event would take place to review how the agreed actions had been met and how the learning was disseminated within agencies. Finally the report is presented to the Board for sign off.

**4. Multi-agency Root Cause Analysis (RCA) or Serious Incident Requiring Investigation (SIRI)**

An investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors - the Root Causes- of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided.

When things go wrong, it can be all too easy to look to apportion individual blame and fault. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Organisations should use their own SIRI procedures if this is deemed suitable. However special consideration should be given to involving Partner Organisations. During the first 72 hours of any incident these procedures should be followed in any case.

**5. Child Practice Reviews**

Child Practice Reviews replaced the Serious Case Review system as the statutory guidance in Wales from January 2013. This process consists of several inter-related parts: Multi-Agency Professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an Extended Review which involves an additional level of scrutiny of the work of the statutory agencies.

http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/wales_wda99597.html

***OTHER APPROACHES***

If the case does not reach the criteria for a SAR, other processes may facilitate learning and identify ways for organisations to improve working together.

These approaches may also help determine whether the case meets the threshold for a SAR and what process should be:

**Case conference**

There is particularly a place for a case conference at the end of the process.

**Single Agency Management Reviews**

It may be appropriate that reviews are undertaken by a single agency. Management Reviews are a critical analysis of that agency's management of the case, will identify lessons learnt and the actions needed to address them.

**Multi-Agency Triaging Review**

Following a safeguarding alert, a multi-agency triaging review may be called by any agency. Each organisation will produce a chronology of their involvement with the adult at risk, to be combined. A meeting of all relevant representatives from partner organisations will be called to discuss the case, with an appropriate person (such as the LA's Safeguarding Manager) as Chair. Decisions and actions will be recorded, including the need to share and embed learning into practice. A second meeting may be required to report on actions and review further information. The format can change dependant on the case.

**Reflective Practice Session**

The original participants in the case may review situations as part of a reflective practice session, chaired by the Safeguarding Adults Manager or other suitable person.

The findings and lessons learned from these approaches will be presented to the Board in order to determine if a case should progress to a Safeguarding Adults Review.

***EXTERNAL SUPPORT***

Colleagues are currently considering a reciprocal agreement across Berkshire to share expertise in carrying out Safeguarding Adults Reviews.