Safeguarding Adults Review (SAR)

Multi Agency Protocol

2017

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Section 1: Multi Agency Protocol

1.1 Introduction

1.1.1 The purpose of this Protocol is:

- To ensure that the Rotherham Safeguarding Adults Board (RSAB) is able to undertake any required Safeguarding Adults Reviews in accordance with its obligations under section 44 of the Care Act 2014;
- To ensure that local practice is in line with the Care and Support Statutory Guidance issued by the government;
- To safeguard and promote individual well-being by working to further protect adults from abuse and neglect;
- To facilitate a consistent approach to the process and practice in undertaking a Safeguarding Adults Review (SAR)
- To provide guidance to the SAB, the relevant supporting SAB sub-group and any convened Safeguarding Adults Review Panels.

1.1.2 Chapter 14 of the Care and Support Statutory Guidance issued in relation to the Care Act 2014 replaces the 'No Secrets' guidance previously issued by Department of Health and Home Office.

1.1.3 The Care Act 2014, which came into force in April 2015, imposed a duty on local authorities to establish a SAB. Section 44 of the Act obligates such Boards to make, in certain circumstances, the arrangements necessary to undertake a SAR.

1.1.4 Section 42 (1) of the Care Act 2014 states that the safeguarding duties imposed on local authorities apply to an adult who:

a) Has needs for care and support (whether or not the local authority is meeting any of those needs) and;

b) Is experiencing, or at risk of, abuse or neglect; and

c) As a result of those care and support needs is unable to protect themselves from either the risk of, or the experiencing of abuse or neglect.

This document will hereafter refer to the adult to whom safeguarding duties apply as Adults.

1.1.5 The Care Act also imposes a duty of co-operation between the local authority and other partners comprising the SAB. Section 6 (1) of the Act states that:

1) A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of:

a) their respective functions relating to adults with needs for care and support;

b) their respective functions relating to carers; and .

c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).

1.1.6 This SAR Protocol is designed to replace all previous Protocols.

1.2 Practice Guidance Background

1.2.1 The Care Act 2014 imposes a duty on local authorities to establish a SAB and under section 44 of the Act; such Boards are required to make the arrangements necessary to undertake an SAR in certain circumstances.

1.2.2 The Act states that:

1) A 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 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) A 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).

5) Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to –

a. Identifying the lessons to be learnt from the adult's case, and

b. Applying those lessons to future cases.

1.3 Purpose of a Safeguarding Adults Review

1.3.1 The SAB will consider what type of review process could promote effective learning and improvement action to prevent future deaths or serious harm from occurring again. Such reviews will also be used to highlight areas of good practice where lessons learned can be identified to be applied to future cases. (Appendix 1)

1.3.2 A SAR must be arranged when an adult in the Rotherham Local Authority area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Each SAR must make efforts to establish what the relevant agencies and individuals involved in the case in question might have done differently to prevent harm or death and findings of practical value to organisations and professionals should be published, setting out what action needs to be taken to prevent a reoccurrence.

1.3.3 Any SAR must reflect the six principles which underpin safeguarding:

- Empowerment – people being supported and encouraged to make their own decisions and informed consent;
- Prevention – it is better to take action before harm occurs;
- Proportionality – the least intrusive response appropriate to the risk presented;
- Protection – support and representation for those in greatest need;
- Partnership – local solutions through services working with their communities, who have a part to play in preventing, detecting and reporting neglect and abuse; and
- Accountability – accountability and transparency in delivering safeguarding.

1.3.4 The SAB will be responsible for agreeing the Terms of Reference for any SAR that they decide to undertake and this document will be published and made openly available. The scope of the review will be influenced in consultation with family members. Records will be anonymised through redaction for the use within the SAR process unless informed consent is sought and given.

1.3.5 The SAB and its partner organisations will ensure that any SAR undertaken will apply the following principles:

- There will be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of Adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews will be proportionate and will depend on the scale, complexity and nature of the issues that are to be examined throughout the review; this will be decided at the start and shared with involved parties.

- It is essential that the SAR is led by individuals who are wholly independent of the case to be reviewed and of the organisations whose actions are being reviewed;
- Professionals will be fully involved within the process and will be invited to contribute their perspectives to the SAR without fear of being blamed for actions taken in good faith;
- Families will be invited to contribute to the SAR. Information will be given to the family members to ensure that they fully understand how they are going to be involved and what they can expect from a Review.
- Families will not attend learning events or board meetings in relation to the SAR but will be able to meet with the Board Chair or manager if needed.

1.3.6 It is recognised that a SAR must be trusted and safe experiences, carried out in an environment that encourages those participating in the process to be honest, transparent and willing to share information.

The purpose of a SAR is NOT:

- To hold any individual or organisation to account
- To reinvestigate or apportion blame.
- To address professional negligence. (Should the review identify any necessary disciplinary action, this should be addressed through agencies' own Disciplinary Procedures. Individual Management Review (IMR) authors therefore need to be cognisant of their agency's disciplinary procedures.)
- An Enquiry into how an adult at risk has died: that is a matter for the Coroner's Court.
- An Enquiry into who is culpable for the death of that adult at risk - that is a matter for the Criminal Court.
- A Judicial Inquiry: there is no oral evidence or cross-examination of evidence.

However, the SAR will take account of a coroner's inquiry and criminal investigation. The SAB will consult with the coroner and the Police if it is deemed appropriate to conduct the SAR in advance of a coroner's enquiry or completion of court outcomes. The findings of the SAR will be made available.

1.3.7 It is acknowledged that agencies may have their own internal/statutory review procedures to investigate serious incidents; e.g. an NHS Serious and Untoward Incident Investigation. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

1.3.8 The Safeguarding Adults Review (SAR) sub-group, will:

- Collate action points and Lessons Learned from individual SAR cases, ensuring all outstanding actions are delivered and that Lessons Learned are clearly disseminated;

- Collate and review recommendations from SARs from other authorities and best practice research to drive continuous improvement in Rotherham; and
- Collate and review recommendations from all partner internal / statutory reviews i.e. statutory Domestic Homicide Reviews, Management reviews, Reflective Practice, Root Cause Analysis and After Action Reviews.

1.3.9 If the SAB decides to not implement any action or recommendation from the SAR then it must include the reasons for that decision within the Annual Report.

Section 2: Operational Procedure

2.1 The SAB should take the lead responsibility for conducting a SAR. The decision to undertake a SAR must be made in consensus. In the event that the Board members cannot reach a consensus, then the Chair of the SAB will make the final decision.

2.1.1 A SAR must always be carried out if:

a)There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

AND

b) The person died and the SAB knows/suspects this resulted from abuse or neglect(whether or not it knew about this before the person died)

OR

c) The person is still alive but the Safeguarding Adults Board knows or suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

2.1.2 A SAR should be considered when:

- An adult has care and support needs, and when abuse or neglect is known or suspected to have taken place, and the adult has sustained:
- A life threatening injury through abuse or neglect
- Serious sexual abuse
- Serious or permanent impairment of development through abuse or neglect;
- Institutional or systemic abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a person's well-being and it is of a nature where there are serious negative outcomes for the individuals concerned;
- Financial abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a person's well-being and it is of a nature where there are serious negative outcomes for the individuals concerned;

- The operational case details give reason for concern about the way in which professionals and services worked together to safeguard the adult at risk
- Following a complaint, including those that are being investigated by the Local Government Ombudsman.

2.1.3 In deciding whether a SAR should be conducted in cases other than those involving a statutory obligation, the following questions should be considered by the SAR sub-group

- Was there clear evidence that the risk posed to an adult was not recognised, or shared, by professionals or agencies?
- Was the adult subject to a form of abuse or neglect as identified within the Care and Support Statutory Guidance https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf
- Does one or more professional, agency, family member, carer or advocate consider that their concerns were not taken seriously, or acted upon appropriately?
- Does the case indicate that there may be operational failings in one, or more aspects of the use of the SAB Policies and Procedures?
- Does the case appear to have implications for a range of professionals roles or agencies?
- Was the adult subject to unauthorised Deprivation of Liberty?
- Was there evidence of discrimination?

2.1.4 If the criteria for a SAR has been met and a death has occurred, the SAR sub-group is advised to liaise with their local Coroner's Office to ensure that the arrangements for undertaking a SAR are acceptable.

2.1.5 Due regard for criminal/civil process should be observed at all times by the relevant supporting SAB subgroup.

2.2 Initiating a Safeguarding Adults Review

2.2.1 Any agency or professional may refer a case that it believes confirms to the criteria and guidance to the Safeguarding Adults Board Manager – Safeguarding Adults.

2.2.2 All referrals will be submitted to the SAR sub-group of the Rotherham Safeguarding Adults Board for consideration. This sub-group will then be responsible for reviewing whether or not a referral meets the criteria. If the sub-group agrees that the referral meets the criteria then a recommendation will be submitted to the Chair of the SAB for final approval. The sub-group will make a recommendation which method of SAR will be used in each case. In the event of a Safeguarding Adults Review Referral being rejected, the reasons need to be recorded in writing by the Chair of the SAR sub-group and shared with the applicant and the Chair of the SAB.

2.2.3 In certain cases, it may be necessary for the SAR sub-group to obtain additional information to enable a decision to be made as to whether a SAR is required. This may include asking key partners to submit initial chronologies to support decision making.

2.2.4 Following approval, the SAR sub-group will be responsible for appointing an Independent Author to conduct the SAR and supported by the Board Manager undertake an initial scoping of the review.

2.2.5 There will be a need to address the budgetary requirements for undertaking a SAR. This will be the responsibility of the SAB. If additional monies are needed to finance a SAR the board chair will write to statutory partners.

2.3. Conducting a Safeguarding Adults Review

2.3.1 The Chair of the SAR Sub Group and the SAB Manager will be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to stages described below and the agreed timescales.

2.3.2 Stage 1 – Establish a Safeguarding Adults Review Panel

The first task of the SAR Sub group is to identify an independent author to conduct the review or establish a panel of reviewers to form a Safeguarding Adults Review panel to investigate the concern. The author will meet with the family to scope the review and clarify/agree further engagement in the process.

2.3.3 Stage 2 - Initial Meeting

The Initial Meeting will agree:

- The Terms of Reference. This document will address the following elements:
- What appear to be the most important issues to consider in order to enhance the points of learning from the specific case?
- How can the relevant information best be obtained and analysed, including any necessity to request relevant individuals to give a direct account?
- Over what time span should case details and chronology of intervention be reviewed?
- What information from family, or service, history will assist the Safeguarding Adults Review Panel?
- Which agencies or individuals should contribute to the review, and is there a need for other written information to be obtained from other sources?
- Should the adult at risk, their family, carers or advocates be invited to contribute to the review? If so, which is the most appropriate method to enable their participation?
- Should an independent advocate be appointed to represent and support an adult who is the subject to the SAR? (NB: where the adult has ‘substantial difficulty’ in being involved in the process and where there is no other suitable

person to represent and support them an independent advocate must be appointed.)

- How should the review process take account of a Coroner's inquiry, or any criminal investigation?
- When should the review start and by what date should it be completed?
- How will confidential information be recorded, stored, and distributed?
- What best practice operational guidance / procedures can be used as a benchmark to measure individual / agency performance?
- The 'evidence' required from each participant to be contained within an Individual Management Review. The SAB Manager will formally request agencies to prepare and submit an Individual Management Review outlining their involvement with the adult at risk/family (Appendix A).
- The support and other resources needed (any perceived deficits to be referred to Chair of SAB)
- The time scales within which the review process should be completed with
- Dates, times and venues of meetings
- The nature and extent of legal advice required, in particular relating to:
- Data Protection; Freedom of Information considerations and the implications of the Human Rights Act 1998.
- Whether there is the need for the completion and implementation of media and communication strategies
- That all records are secured immediately by each relevant organisation and made available to the IMR author

2.3.4 Stage 3 – Evidence Gathering

Each agency asked to complete an IMR will inform the Board manager of the name of the IMR author(s). The IMR authors will be invited to meet with the Board Manager or the Independent Author, to ensure a consistent approach and to identify and resolve any barriers to completing the work. The IMRs will incorporate a detailed chronology of events, highlighting any discrepancies. IMRs will also provide recommendations for action. IMRs MUST be quality assured and signed by the relevant agency representative on the SAB prior to submission.

2.3.5 Stage 4 – Receipt of Evidence

This stage of the process is a formal session where agencies will share their IMRs and all other relevant information. IMR authors may be invited to the meeting to clarify and raise queries from their reports. All information must be submitted to the Board Manager prior to the meeting. Each agency involved will be asked to:

- Present their Individual Management Review and any other management reports and relevant information
- Cross-reference all agency management reports and reports commissioned from any other source

- Form a view on practice and procedural issues
- Agree the key points to be included in the final Overview Report and the proposals for action

2.3.6 If at any stage whilst undertaking the procedure information is received which requires notification to a statutory body, e.g. General Social Care Council (GSCC) or DfeS, regarding significant omission by individual/s or organisations this should be undertaken by the SAR sub group Chair without delay. The Chair of the SAR Sub-group should report back to the Chair of the Safeguarding Adults Board and a decision made as to whether the SAR process should be suspended pending the outcome of such notification.

2.3.7 Stage 5 – Production of the Overview Report

The SAB Manager will advise the SAB Chair on the production of the Overview Report, which brings together information, analyses it and makes recommendations. The SAR report should:

- Provide sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

The SAB manager will work with the IMR authors, relevant organisations and the SAR author to ensure the report is complete within agreed timescales. The SAR Sub-group will monitor and ensure quality assurance of the overview report to ensure it meets the required standard for the Safeguarding Adults Board.

2.3.8 Stage 6 - Implementing the Review Recommendations

On completion, the Overview Report will be presented to the Safeguarding Adults Board, which will:-

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report.
- Ensure that the Overview Report contains an Executive Summary which can be made public, including key learning points for agencies.

2.3.9 The action plan will indicate:

- Who will be responsible for various actions/recommendations.
- The time-scales and targets for the completion of agreed actions/recommendations.
- The intended outcome and purpose of recommended actions/recommendations.
- The model used for evaluating, monitoring, and reviewing the necessary improvements in practice, policy, and/or systems.

- Clarify to whom the report, or sections of the report, should be made available.
- Mechanisms for the dissemination of the report, or key findings to interested parties and provide feedback and debriefing to staff, adult at risk, family, informal carers and media.

2.4 Engaging with Families

2.4.1 There should be clear consideration given at the outset as to any specific inputs that the family, relatives or the person who is the focus of the SAR should make or are encouraged to make (for example shaping the Terms of Reference or how the person who is subject of the SAR is referred to in any report). It is expected that the report author is the lead liaison with the family for matters concerning the review process.

2.4.2 Involving the adult at risk (if they have survived) and/or their family are significant to the SAR process, whichever methodology is used. The purpose of a SAR and the process it follows will be unfamiliar for the 'adult at risk' and/or their family, adding to their distress and inevitable concerns. It will be a very sensitive time for everyone and consideration should be given at an early stage as to how this will be done; the ongoing identified support to those involved (how and who will provide it) with timely discussions taking place with the family or adult at risk, as to how the process will work, how they want to be involved and the type of outcomes that are likely from a SAR in general.

2.4.3 The SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care act, where an adult has "substantial difficulty" in participating, this should involve representation and support from an independent advocate or their family member/friend where appropriate.

2.4.4 If a decision is taken to not involve the adult at risk or their family, the reasons should be informed by legal advice and recorded.

2.4.5 Updates will be given at key stages of the review and before the publication of the report. It is likely that the Board Manager will fulfil this role.

2.5 Publication of the Safeguarding Adults Review

2.5.1 The SAB recognises collective responsibility, open and transparent governance and the need for evolved learning. However, considerations of reputational risk or national learning arising from the case may affect decisions as to how the report is published. The SAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the SAB webpage, which at present is part of the

council's website. Agencies and SAB members can provide the relevant links as required. This will be kept under review.

2.5.2 The SAB manager will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with prevailing Information Sharing Agreements, the Data Protection Act, Information Governance arrangement and other legal requirements.

2.5.3 The Care Act requires the SAB to publish the findings of any SAR in its annual report, recognising the transparency and disseminating learning but doing so within the legal parameters of confidentiality, setting out how learning will be implemented. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

2.5.4. Any reports to be published must be fully anonymised. However, in doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised nomenclature.

Section 3: Quality Assurance

3.1 Governance and Accountability

3.1.1 The SAR sub-group will ensure that all planned actions are implemented. The action plan will remain on the sub-group agenda until such time that all recommendations have been implemented.

3.1.2 All Safeguarding Adults Reviews conducted within the year should be referenced within the Safeguarding Adults Board's Annual Report and Strategic Plan along with relevant service improvements.

3.1.3 The SAR sub-group will be responsible, on behalf of the Safeguarding Adults Board, for sharing Lessons Learned throughout the partnership and disseminating good practice.

3.2 Performance Monitoring

3.2.1 There will be an evaluation of each Safeguarding Adults Review to ensure that due process was followed and that appropriate arrangements were made to engage the family members of the service user.

3.2.2 The findings of any SAR will be documented in the Safeguarding Adults Board's Annual Report, as well as what action has been taken or will be taken in relation to the findings.

3.3 Practice Guidance Review

3.3.1 This guidance note will be reviewed on an annual basis and in accordance with legislation.

Appendix 1

Safeguarding Adults Reviews methodology options**

The model has 3 methodology options for conducting Safeguarding Adults Reviews, from which local Safeguarding Adults Boards can decide upon the most appropriate in each case.

An overview of methodology/process, level of flexibility and relative benefits in relation to each review is outlined below and to help inform local decision making.

Option One – traditional SCR approach

In this option the SCR methodology is reflected in most local protocols and follows a traditional model, broadly thus:

- Appointment of SCR panel, including chair (usually independent) and core membership-which determines terms of reference and oversees process
- Independent report author (overview report, summary report)
- Involved agencies produce Individual Management Reports (IMRs), outlining involvement and key issues
- Chronologies of events
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships

This more traditional SCR methodology is more likely to be deemed applicable where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

<u>Advantages and disadvantages of review approach</u>

The relative merits and drawbacks of this SCR methodology are outlined below

Advantages	Disadvantages
More familiar to SAB/stakeholders, who may consider it more robust/objective	Overly bureaucratic
Where public/political confidence may only be assuaged via a tried and tested approach	Protracted-implementation of lessons learnt/recommendations not sufficiently responsive to time considerations
Where there is multiple abuse, or high Costly-costs may not justify the 10 profile cases/serious incidents	Costly-costs may not justify the outcomes
Methodology usually reflects that of Children SCRs/Domestic Homicide	Often deemed punitive, attributing blame

Reviews (DHR)	
	Frontline staff often precluded, so disengagement from process and subsequent learning

Option Two – Action Learning Approach

This option is characterised by reflective/action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement.

This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes: (completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

Further Variance

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documentation review, staff interviews and report production. However, the final decision will be determined by the Safeguarding Adults Board in

consideration of the best fit and individual preferences in the light of the case in question.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

Advantages and disadvantages of review approach

The relative merits and drawbacks of this review approach are outlined below

Advantages	Disadvantages
Significant evidence approach is much more efficient	Methodology less familiar to many
Swiftness of conclusion and embedding the learning	
Considerable reduction in overall costs compared to more traditional approaches	
Action learning approach enhances: • partnership working • mutual recognition of alternative partner perspectives • collaborative problem solving	
Involvement of both frontline staff/senior managers secures both strategic and operational perspectives	
Unique perspective of staff involved in the case, reflective of the systems operating at the time	
Approach allows for identification of system strengths/positive practice	
Learning take place through the process and there is enhanced commitment to its dissemination	

Option Three – Peer Review Approach

This option is characterised by peer reviews and accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, (for instance a Safeguarding Adults Board members), or other agencies within the region.

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice. Such reviews can be cost effective and spread learning.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the Safeguarding Adults Review.

The appointed peer team/panel should agree the Terms of Reference and specific methodology with the Safeguarding Adults Board.

Advantages and disadvantages of Review Approach

The relative merits and drawbacks of this review approach are outlined below

Advantages	Disadvantages
Objective, independent perspective to particular case/aspects of safeguarding practice	Capacity issues within partner agencies may restrict: • availability • responsiveness
Usually via trusted sources sharing common experiences/understanding	where political or high profile cases deems local oversight is preferable
Can be part of reciprocal arrangements across/between partnerships	
Very cost effective, usually no fees incurred	

Other safeguarding Reviews

The above 3 options outlined are in the context of options for Safeguarding Adults Reviews. However, the methodologies can be adapted to other forms of safeguarding reviews, where serious case thresholds have not been met.

Some of the circumstances where other safeguarding reviews may be beneficial include:

- A retrospective review of a complex safeguarding case, to reaffirm or amend practice
- Challenges have been made to local practice or procedural interpretation

- Multiple incidents/repeated concerns with particular service providers
- Auditing of multi-agency safeguarding activity or scrutiny of specific aspects of practice

Single Agency Review

Single Agency Reviews can be conducted where agencies constituent to the local Safeguarding Adults Board are undertaking their own reviews, where there is a safeguarding element, but where there are no implications or concerns regarding involvement of other agencies. This would be appropriate where there are lessons to be learnt regarding the conduct of an agency and in the absence of the need for a multi-agency review.

These could encompass circumstances such as:

- Serious Incidents
- Safeguarding (or other relevant) data indicating a council is an "outlier" and the need for further investigation/analysis conducted by health partners
- The Board requesting a SAR from an agency in the light of emerging issues/concerns in relation to a particular case
- Where serious harm and/or abuse was likely to occur, but had been prevented by good practice

It is recommended that the Safeguarding Adults Board is informed by any constituent agency when they are undertaking a Single Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships.

Advantages and disadvantages of Review Approach

The relative merits and drawbacks of this review approach are outlined below.

Advantages	Disadvantages
Opportunity for agency to scrutinise aspects of practice in relation to specific areas and:	Restricted scope - does not embody a wider perspective of other partners
in order to identify areas for improved practice	Lacks interface perspective(s)

Single agency reviews represent an opportunity for an agency to scrutinise aspects of its own practice in relation to specific areas and in order to identify opportunities for improved practice.
They can be carried out exclusively by the partner agency concerned or undertaken or facilitated by an external agent on their behalf.

By definition, its scope is restricted, in that it does not embody a wider perspective of the practices of, or interfaces with other partners.