14. Learning from Safeguarding

Tameside Adults Safeguarding Partnership Board

14.1 Safeguarding Adult Reviews (SARs)

Organisations should refer to the https://www.tameside.gov.uk/socialcare/adultabuse/tasp

This document sets out the arrangements by which a Safeguarding Adults Board (SAB) will conduct case reviews. It highlights the statutory duties, overall process for running a Safeguarding Adults Review (SAR), and how the SABs will commission such work. The core process that the SAB) will utilise for all case reviews (both SARs and other reviews) is set out in this document.

TASPB will arrange a Safeguarding Adult Review (SAR) when an adult in Tameside 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.

TASPB will also arrange a SAR if an adult in Tameside has not died, but TASPB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, 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. TASPB will also consider a SAR in any other situations involving an adult with needs for care and support.

TASPB are primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. TASPB Learning Framework explains in more detail how this will be applied in practice.

Consider the appropriateness of an early discussion to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for TASPB to arrange a review in relation to them.

TASPB will reflect the six safeguarding principles in the context of the SAR. Terms of Reference will be agreed and these should be published and openly available. When undertaking SARs the records will either be anonymised through redaction or consent should be sought.

The following principles will be applied by TASPB and partner organisations to all reviews:

- 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 should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professional's should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

TASPB will 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 that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. 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. The recommendations and action plans from a SAR will be followed through by the Safeguarding Adult Board.

TASPB will endeavour to ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and, or, their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- Strong leadership and ability to motivate others.
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive.
- and complex group dynamics.
- Collaborative problem solving experience and knowledge of participative approaches.
- Good analytic skills and ability to manage qualitative data.
- Safeguarding knowledge.
- Inclined to promote an open, reflective learning culture.

TASPB will aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort will be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

14.2 Links with other reviews

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

In setting up a SAR, TASPB will also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SCR or DHR, a criminal investigation or an inquest.

Prior to a SAR commencing TASPB chair will communicate with the Coroner as appropriate to notify them of TAPB intentions to conduct a SAR. Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

14.3 Findings from SARs

TASPB will ensure that learning is shared across organisations. TASPB will include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take in relation to those findings. If TASPB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation that TASPB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

SAR reports should:

- provide a 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