Brent Safeguarding Adults Board – Case Review Group (BSAB-CRG)

Safeguarding Adults Review (SAR) Referral Policy & Procedure
March 2017

If you have any queries about this procedure please email: brent.lsab@brent.gov.uk

Brent Safeguarding Adults Board
Case Review Sub Group - Safeguarding Adults Reviews(SAR)
Policy & Procedure)

Terms of Reference of the Case Review Group

1. **Aims**

To commission and oversee the conduct of case reviews that require lessons to be learned, including Safeguarding Adults Reviews (SARs) as detailed in the Care Act 2014. To provide a mechanism for the LSAB to deliver reviews that do not meet the threshold for a SAR. It also aims to ensure that lessons learned are shared, acted upon and impact is assessed.

2. **Functions of the Group**

- To receive referrals of cases to be considered as Safeguarding Adults Reviews
- Consider these cases against the statutory criteria for Safeguarding Adult Reviews as detailed in Care Act 2014 and the Statutory Guidance (DH, 2016). The Chair of the Group will make the final decision as to whether the case proceeds for recommendation to a Safeguarding Adult Review
- Refer cases that are deemed by the group to meet the definition of a SAR to the SAB Independent Chair for the final decision
- Where a SAR is commissioned the group will appoint a panel from relevant agencies to oversee the delivery and completion of the review, reporting regularly to the SAB
- When a SAR is completed, the group will review the final report and make a recommendation to the SAB as to next steps to implement the learning
- Lead the initiation and delivery of reviews of cases that do not meet the criteria for a SAR, making final recommendations to the SAB
- Ensure proportionality of these reviews in the methodology adopted
- Monitor and evaluate progress of actions to ensure lessons learned from SARs and from non-SAR reviews
- Once actions arising from reviews are agreed, to pass information to the Monitoring & Evaluation sub group to monitor delivery and impact
- Link with the LSCB as necessary and Safer Brent Partnership, the Coroner and other groups as relevant
- Work with other SAB Sub Groups to ensure multi-agency activity is co-ordinated and business plan activities are delivered. In particular, this group will work closely with Learning & Development and Monitoring & Evaluation sub groups.

3. **Membership:**

The group will include;

- Brent Council Children's Social Care
- Brent Council Adult Care
- Voluntary Sector representative
- Metropolitan Police
- Brent CCG

- Senior Manager/General Practitioner - Central & North West London NHS Foundation Trust
- London North West Healthcare NHS Trust
- National Probation Service

4. Chair

The group will be chaired by a statutory partner representative.
The Vice Chair will be: TBC

5. Relationship with other Subgroups

- To communicate any Learning from SARs and other Reviews to the Learning & Development Subgroup
- To work closely with the Monitoring & Evaluation Subgroup to inform the groups programme for monitoring and evaluating the impact of SAB activity
- To ensure communication plans to share learning from SARs and other reviews includes the wider BSAB membership and Partnership Boards where appropriate

6. Membership Expectations & Committment

The Care Act 2014 requires statutory partners to contribute financially and in kind and members must attend meetings. The time commitment is approximately 5/6 hours per month but this will vary depending on the activities of the group.
A role description for SAB Subgroup members is attached.

7. Reporting and Accountability

The group will report to the LSAB Executive Group on progress against delivery of Business Plan priorities. It will provide a quarterly report to the BSAB Executive Group, and annual summary report as part of the BSAB annual report.

The group will raise issues that need resolution beyond the remit of its members to the BSAB Executive Group, who will forward to the Board if these cannot be resolved.

8. Frequency of Meetings

The group will meet quarterly but more frequently when occasion demands.

9. Conduct

Members of the Safeguarding Adults Case Review group will conduct the business of the group having regard to the six key principles that underpin all adult safeguarding work:

Empowerment – Personalisation and the presumption of person-led decisions and informed consent.
Prevention It is better to take action before harm occurs.
Protection Support and representation for those in greatest need.
Partnership Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect.
Accountability Accountability and transparency in delivering safeguarding.
Proportionality – a measured response that considers the risks and benefits for all involved

Appendix 1
Membership of the Safeguarding Adults Review Group 2016-17

	Name	Organisation	Role
Chair: Temporary	Michael Preston-shoot	Independent Chair	Chair (temporary basis)
	Christine Bakunga-Muyizzi	Brent Council	Transitions Team Manager
	Catherine Knights	CNWL NHS Foundation Trust	Associate Director of Safety and Safeguarding
	Christine Dyson	Brent CCG	Designated Safeguarding Nurse for Adults
	Catherine Crawford	Safeguarding Adults Board	Business Manager
	TBC	Metropolitan Police Brent	
	Jon Norris	Brent Adult Social Care	Safeguarding Adults Team Manager
	Anne Lawn	SENSE	Head of Operations (South)
	Samantha Drury	Age UK	Lead Nurse - Integrated Services

NB: The Safeguarding Adults Review Group is not the same as the Safeguarding Adults Review Panel. The Panel will be constituted by the Independent Chair of the Safeguarding Adults Executive Board when it has been decided to conduct a Safeguarding Adults Review. Membership of the Panel will be determined by the case to be reviewed.

Appendix 2
Criteria for Safeguarding Adult Reviews: Care Act 2014

An 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 other 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) An 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 co-operate 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.

Questions to consider:

- ✓ Does/did the person have care and support needs?
- ✓ Are/were there agencies involved in providing care and support and if so, one or more?
- ✓ Is/was there a concern about how agencies worked together?
- ✓ Has the person died?
- ✓ Is it known or suspected that the death resulted from abuse or neglect?
- ✓ Is the person still alive?
- ✓ Is it known or suspected that the adult has experienced serious abuse or neglect?
- ✓ If the person still alive, what is the persons view about being the subject of a review?
- ✓ Is the person able to give consent to being a subject of a review, and if not, has the person's capacity been assessed with regard to this decision and a best interest process been undertaken?

- ✓ What is the person's family member or attorney's view of the person being the subject of a review?
- ✓ What work, if any has been done with the person who has experienceds harm, and/or their family?
- ✓ Are there any issues that need to be considered with regard totiming of the review?Is there public interest in the case?
- ✓ Are there lessons to be learned from the case?
- ✓ Is the process the same, or different where there are more one person who has been subject to serious abuse or neglect? E.g. Winterbourne View; Rotherham etc.

Appendix 3
Safeguarding Adults Review (SAR) Pathway

In considering cases, members of the BSAB-CRG will be always mindful of the six Safeguarding principles listed under **conduct** above.

The Chair will establish a safe learning environment, and members will adopt a spirit of enquiry in order to learn and understand what has happened. Members will avoid advice-giving and apportioning blame.

The SAR Pathway has10 steps. These are:

1) Receive referrals and clarify basic information
2) Refer case to the BSAB-CRG for consideration
3) BSAB-CRG clarifies information (questions to help to shed light on the situation rather than analyse the incident)and tests to see if the case meets the SAR Criteria (see APPENDIX 2)
4) BSAB-CRG checks if other investigations taking place and the implcations of this.
5) BSAB-CRG decides if additional information required and timeframes for collection
6) BSAB-CRG recommends a particular type of review or NFA
7) BSAB-CRG Chair to make a recommendation to the Independent Chair of the BSAB.
8) SAR Panel set up and SAR conducted
9) Findings and recommendations identified by SAR Panel
10) BSAB-CRG/SAB Executive Group decides how learning is to be shared/disseminate

Appendix 4 – Referral Template
Referral to Brent Safeguarding Aduts Board – Case Review Group (BSAB-CRG)

Date referred to BSAB-CRG	
Case Identifier:	
Borough of ordinary residence	
Details of Referrer/referring agency	
Has the person died? If so, please give date of death	
Does the person's family, or representative know that a SA review is being considered?	
Enquiries completed to date & by agency e.g. S42/Safeguarding; IMR etc.	
Brief summary of the circumstances that led to the death, or to serious harm to the person, including where the harm occurred/where the person died.	
Does/did the person have care and support needs? If so, when were these assessed and what were/are they?	
Please give details of key agencies involved in providing care and support to the person.	
Is/was there a concern about how agencies worked together? Please say what these were.	
Is it known or suspected that the adult had experienced serious abuse or neglect? If so, can you give some details of what the initial evidence for this may be?	
Who are the people in the person's family who may have a legitimate interest in the SA review?	

What work, if any has been done with the person who has experienced serious abuse or neglect; and/or their family?	
What support is being offered to assist family members with their loss where a death has occurred?	
How do the family want to be involved in the SAR and what support might they need?	
Are there any issues that need to be considered with regard to timing of the review? E.g. Coroner; police investigation etc.	
Is there public interest in the case? If so, what is this likely to be?	
Are there any themes emerging from the work done to date that indicate that there will be opportunities for learning? Please include any themes that are emerging from initial enquiries.	
Might a SA review prevent harm occurring to others in similar circumstances? If so, in what way?	
Recommendation to Chair of the BSAB, including type of review (to be completed by the BSAB-CRG Chair)	
1. Formal SAR with independent reviewers	
2. Local SAR with internal reviewers	
3. Desk-top review	
4. Reflective practice session	
5. Other	
6. No further action	
7. Cannot make a recommendation	
Balance sheet of factors weighed in making the recommendation	
Estimate of cost	
Date of report:	**Author:**

Appendix 5
Learning from Safeguarding Adults Reviews

The case that you agency was involved with (BSAB-CRG ref.)	Summary of Learning from the SAR?	How the Learning has been disseminated?	What has changed as a result of the SAR ?
Date:	**Agency & name of person completing this form:**		

To be reviewed March 2018