Safeguarding Adult Review (SAR) and Assurances Framework

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Foreword

The Bexley Safeguarding Adults Board recognises and values the opportunity to ensure that the partnership learns, develops, and uses a reflective approach for all reviews.

This Protocol is designed to explicitly set out the ***statutory*** roles and responsibilities within Bexley for Safeguarding Adults Reviews and to clarify the governance arrangements relating to such reviews for the Bexley Safeguarding Adults Board.

Bexley have incorporated the requirements of the Care Act 2014, and are adopting the term, 'Safeguarding Adults Reviews' known as, SAR, for all safeguarding learning reviews regardless of which method is used to achieve learning. All Safeguarding Adults Reviews are of equal significance and value to the BSAB.

Safeguarding Adults Reviews are essential in helping the Board prevent abuse and neglect of adults at risk and learn from cases and situations that challenge us as a multi-agency partnership.

The Care Act 2014 makes safeguarding ***everyone's responsibility*** to safeguard adults at risk and together I am certain we can achieve better outcomes based on the learning we receive.

It is important to remember that ***anyone*** can make a SAR Notification to the BSAB about the ***death or serious incident*** of an adult (or group of adults) at risk living in Bexley.

It is the BSAB's expectation that ***all partners and agencies working with adults*** in Bexley use this SAR Protocol and Toolkit to have consistency, governance and understanding of the SAR process and to embed the learning found through SAR.

It is my expectation as the Independent Chair, that all partners continue to give assurances to the Board by active participation in the review process and will continue to reflect, learn, and develop safeguarding practice in Bexley.

Andy Rabey

Independent Chair – Bexley Safeguarding Adults Board

What is a Safeguarding Adult Review (SAR)

The purpose of a SAR is to prevent serious harm or the risk of serious harm to adults at risk of abuse or neglect by learning from complex cases that agencies find challenging, which, on initial analysis, demonstrate areas of practice that could have been delivered more effectively and additionally, where there are clear concerns that agencies have not worked as well together as they might.

A SAR in Bexley may be any case review where the s.44, (4) duties have been agreed; including the use of already completed Reviews with learning. For example, LeDeR or Serious Incident Reviews and/or Coroner's Reports.

A SAR's purpose IS to:

- establish the facts, including those opinions and views of the family and carers close to the adult
- establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of the adult) work together to safeguard adults at risk
- review the effectiveness of procedures (both multi-agency and those of individual organisations)
- inform and improve local inter-agency practice and commissioning arrangements by acting on learning and developing best practice
- prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action

The SAR should consider National Learning Themes and any identified Quality Markers.

What are the Legal Reasons for a SAR

Section 44 : Safeguarding Adults Reviews says:

(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 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) 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 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

The BSAB recognises that on occasion there may be discrepancies between agencies or services where a SAR is agreed and findings are made, which is why the Terms of Reference (TOR) for all SAR's must be clear, concise and escalate when needed to ensure the SAR is about learning.

A SAR is not - A SAR is explicitly ***not*** about blaming any agency, service or individual. However, it will be expected of all agencies to embed the learning and its findings with accountability to the Board. It should also be noted that this process is ***not*** intended to simply focus on the most dramatic and harmful cases, but on those that afford maximum learning in Bexley.

In summary, they are not:

- to investigate or apportion blame.
- to address professional negligence - Should the review identify necessary disciplinary action this should be addressed through agencies' own Disciplinary Procedures and authors therefore need to be cognisant of their agency's disciplinary procedures. Where potential disciplinaryor poor practice is highlighted, the BSAB may ask for further actions to be considered so that safeguarding assurances can be given
- 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 Courts.
- a Judicial Inquiry: there is no oral evidence or cross-examination of that evidence. It is acknowledged that agencies may have their own internal/statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these but use these as part of the SAR process.
- Additional reports and information may be asked to be submitted to the SAR

The SAR & Learning Subgroup

What does the SAR and Learning Subgroup do?

The Subgroup will ensure the statutory responsibilities of the Board are carried out in respect of Safeguarding Adult Reviews (SARs), Serious Incidents (SI) and Learning Disability Mortality Reviews (LeDeR); where appropriate participate in Domestic Homicide Reviews (DHR-DARDR); and any other safeguarding learning where applicable will be monitored in this subgroup.

Their Key Objectives are to:

- To ensure the statutory responsibilities of the Care Act 2014 are upheld, monitored and followed by having a robust SAR Protocol, which includes:- Notifications, Scoping and Rapid Reviews, Decision-Making and Evidence of Learning.
- To ensure there is a vigorous process for commissioning and conducting SARs and other BSAB led review.
- To consider a Local Reviewer Programme to support Professional Development and embed learning across Bexley.
- To share learning points from cases and take to the Executive Meeting and/or Board any learning across the partners; including identification of learning from broader Reviews (e.g. National, Regional, Conferences).
- To consider other learning reviews; including DHR, SCR, SI, LeDeR, where cross-sector learning on safeguarding adults can be shared and attend those forums to share learning and challenge where appropriate the lack of evidence given.
- To review the submitted KPIs for SAR learning against the BSAB Learning Review Delivery Plan and actions.

Meeting arrangements:

The Chair of the SAR Subgroup has been appointed to the Deputy Direct of Adult Social Care. The SAR Subgroup will meet every 6-7 weeks to decide whether the partners believe the SAR criterion, under the Care Act 2014. Sometimes the SAR Subgroup will need to make decision outside the meeting due to urgency of the concerns raised.

Membership:

Is subgroup is made up of all statutory partners, allied and acute health and any other specialist area service that may be required to attend.
Note: The SAR Subgroup must be quorate with LA, Police and Health, as they make up the SAB as outlined in statute for decision-making.

Reporting arrangements:

BSAB members will be responsible for sharing the agreed SAR Report within their own agencies. They will also be responsible for ensuring that appropriate activities to share and facilitate earning have been put in place within their organisation.

Governance:

The BSAB Independent Chair will ultimately be responsible for signing off a safeguarding adult review process. Prior to sign off, the Executive members will receive a copy of the report for comment and to submit their actions. Then once signed off the BSAB full board will receive a copy to share with their services and respond to the actions recommended. Refer to the SAR protocol.

Annual Reporting :

The statutory BSAB Annual Report will identify and publish any Reviews commissioned/concluded over the year period; including all learning lessons identified across the sector and where the BSAB has actions from Reviews and update on those actions.

The SAR process: Step by step

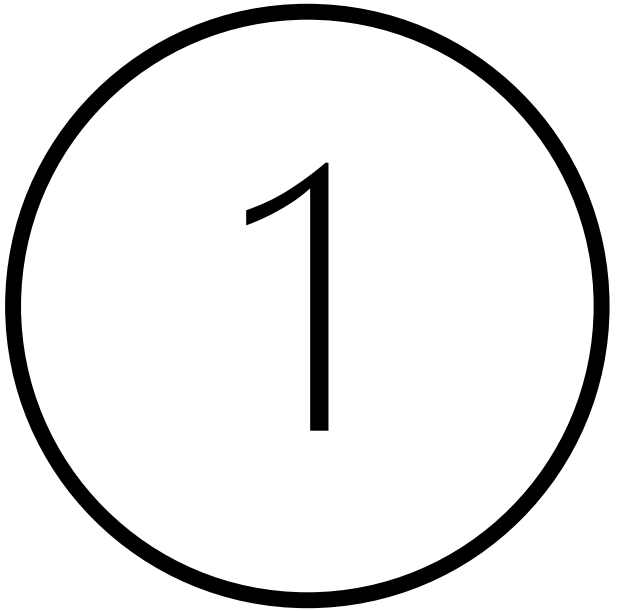
Step 1: Notification form

The SAR Notification can be made to by anyone, including family, friends, and carers. It's an electronic form which is securely sent to the BSAB Business Team as an alert. You can find the Form here – SAR Notification form (see Appendices). Note: A SAR Notifications does not equate to a commissioned review.

The SAR Notification acts also as a Serious Incident Notification (SIN) to Head of Safeguarding Adults and Deputy Director for the London Borough of Bexley's Adult Social Care Services. The SIN will allow the Local Authority to have oversight and give assurances that all other children, young people, and/or adults are safe from harm.

It's the expectation of all partners to complete a SAR Notification from when an adult with care and support needs , whether in receipt of services has died unexpectedly and there are concerns relating to abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused. Concerns are about systemic failings relating to multiple organisations and so there is potential to use learning to improve multi agency practice and partnership working

All SAR Notifications will be verified by the BSAB Business team and where an adult has identified care and support needs will trigger Step 2 - SAR Scoping.

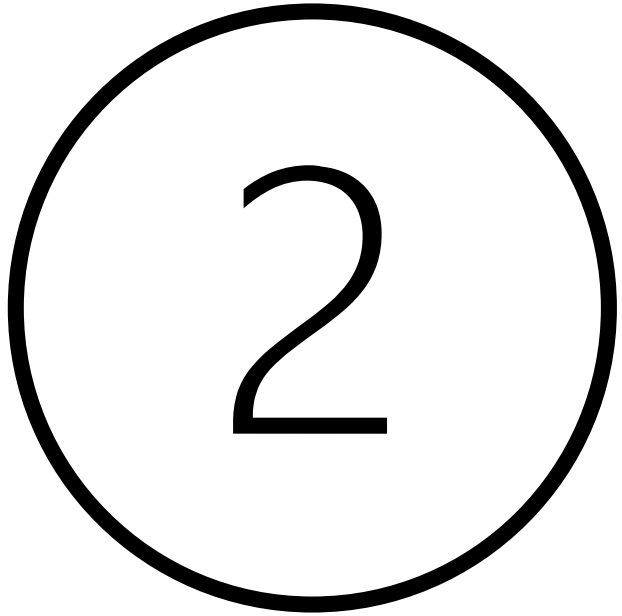


Step 2: SAR Scoping

Once the SAR Notification Form is received and it's been verified that the individual has care and support needs, a pdf version of the Notification and a SAR Scoping Form (see Appendices) request will be sent to:

- SAR Subgroup members
- Any other named agency relevant to the individual(s) being notified - such as: GP or Specialist NHS teams.

The Scoping Form is where agencies involved with the individual analyse and report on what their professional interactions, including any concerns and actions taken with the individual(s) being considered. Then submissions from all agencies, will be shared with the SAR Subgroup for decision-making (see Appendices).



Step 3: SAR Subgroup Decision Making

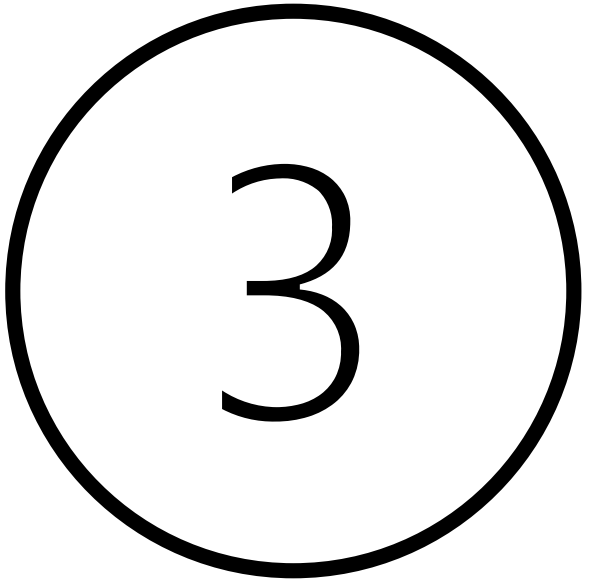
Once all Scoping Forms have been returned, the information will be collated by the BSAB Business Team and shared with the SAR Subgroup so that the partners can analyse and decide whether the criteria of the Care Act s.44 has been met.

The Decision-Making Form (see Appendices) will be used during the meeting to ensure that consistency and standardised decision-making is made for all SAR outcomes.

Where s.44 criterion is **not met**, the SAR Subgroup members may still ask for more information, such as:

- Any urgent safeguarding actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review; and/or
- Working with relatives and/or the individual involved (where death has not occurred and when appropriate); and/or
- Seek any information that will give the BSAB assurances that learning is required and then embedded into practice across Bexley.

Where s.44 criterion **is met**, the SAR Subgroup members will share the Decision-Making Form with the Independent Chair to notify them.



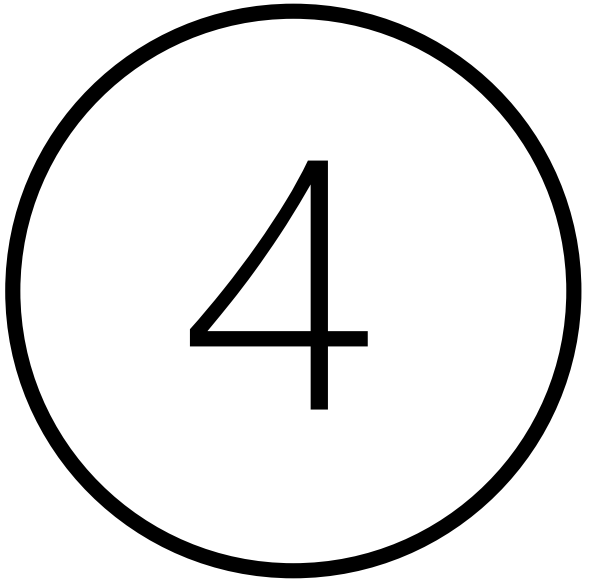
The decision to commission a SAR is the duty of the BSAB and not any individual agency or person.

Step 4: Notifying the BSAB Independent Chair

Once the SAR Subgroup has decided the criterion has been met, the Chair of the Subgroup will share with the BSAB Independent Chair their rationale for final approval.

The Independent Chair will have 20 working days to scrutinise the decision to commission a SAR.

On rare occasions, they may ask for other information or other actions to be taken.



Step 5: Commissioning a Review

Once the Independent Chair confirms the decision to commission a SAR, the BSAB Business Team will be tasked with the following:

- A meeting will be set up by the BSAB Business Team where statutory partners will nominate a mandated person to be the representative at the meeting. This should be someone who has capacity within their workload to take on this task, be senior enough to make decisions and lead change and give constructive engagement to the SAR process for learning.

- Sourcing a SAR Reviewer – there is no set way to source a Reviewer. Unlike Children's and Domestic Homicide Reviews (DARDR) there is not an overarching body to allocate the Reviews to a Reviewer.

- The BSAB Business Team will ask for the National SAB Network to share the SAR Reviewer characteristics out for scoping of a Reviewer. Once shortlisting is completed, the Reviewer is sent a BSAB SAR Reviewer Contract (see Appendices) which gives details for the legal aspects of the SAR; including the ownership rights, Data Protection and Expectations for completion timetable.

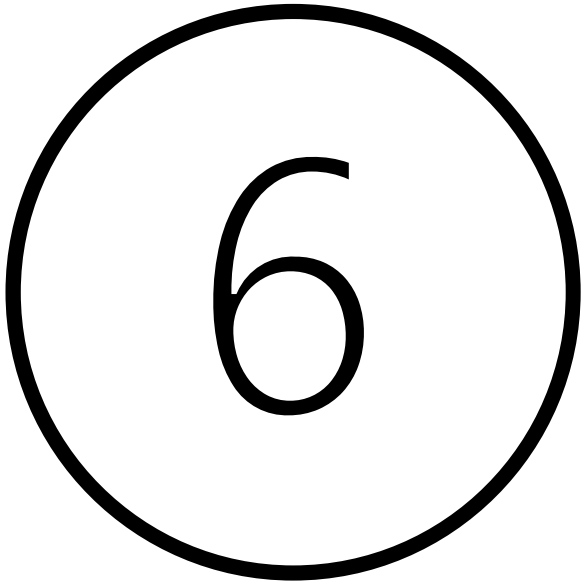
- Once the contract is signed, an agreement is made with the Reviewer and the BSAB Business Team and together they plan the SAR panel meetings based on the initial requirement for the Terms of Reference (see Appendices).

STEP 6: Terms of Reference meeting with Independent Reviewer Officer (IRO)

The BSAB Business Team will organise the first Terms of Reference Meeting within 4-6 weeks of the decision to commission a SAR. The BSAB Business Team will meet with the Reviewer prior to the meeting and invite the SAB Executive Members (LA, ICB and Police representative) Panel, to agree how the review should be conducted, who should contribute and what specific questions the Reviewer will be scrutinising.

The TOR for the SARs will cover the following items:

- Background & Context
- Meeting the SAB duty to conduct a Safeguarding Adults Review
- The Purpose of a SAR
- SAR Management
- SAR Methodology (see Slide 7 and Appendices)
- Agencies who will/have been asked to submit reports
- Action to be taken if there is a failure by agencies to co-operate with a SAR request
- Specific Issues to be Addressed
- Information sharing and confidentiality
- Previous Safeguarding Adult Reviews
- Issues relating to ethnicity, disability, sexual orientation, or faith
- Known research that may contribute
- Participation of the Family
- SAR Governance
- Period the Safeguarding Adults Review will cover and report completion
- Parallel Proceses
- Media Strategy (see Appendices)
- Legal Advice



STEP 7: Practitioner/Panel Meetings

The terms of reference for the Safeguarding Adult Review will dictate the format for the review and which methodology to use. For example, a SAR may require Panel Members to invite front line workers to a meeting with the Reviewer to go through chronologies and IMR's (information management reviews) this is called a Practitioner Event.

Other meetings may be organised to meet with a professional in a 1:1 or team meeting to capture their views.

It is important that professionals engage in the review meetings, reflect on their practice and other practices, share learning and provide clear evidence of information when reporting.

Support is offered before, during and after the SAR process by the BSAB Business Team. This includes one on one training on the SAR process from start to finish.

Step 8: Sign Off, Publication, Action Plans

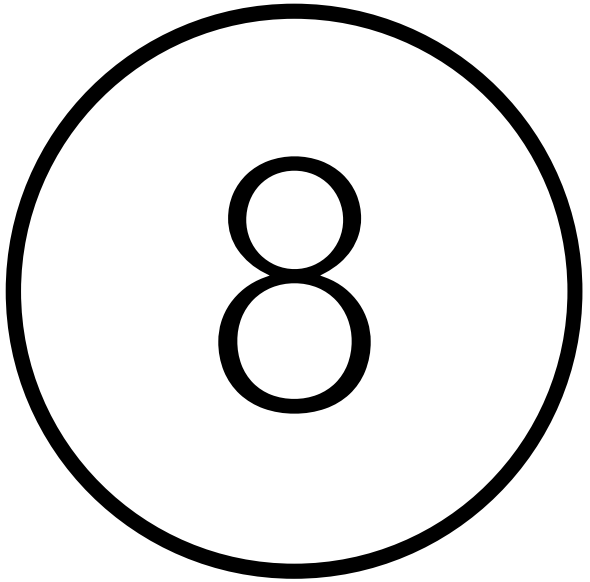
Once the Reviewer has conducted the review, they will share a draft report with findings and recommendations with the Review Panel. The Review Panel address and respond to any outstanding actions the Reviewer has requested by the deadline set.

Once the Reviewer has submitted their Final Draft Report, the BSAB Business Team will share the Final Draft Report with the BSAB Executive Members in addition to the Review Panel for oversight.

The BSAB Executive Members will then give their sign off. There may be additional scrutiny here, if so, then the SAR Reviewer will consider the changes and decide on next steps, an example may be:

- Send the Report back to SAR Panel Members and Reviewer to answer unclear or unconcise statements or findings. If this happens, the Bexley SAB will have to re-sign off on the updates The 'signing-off of the Review(s)' implies that they will take the lead to ensure the learning is shared, embedding and will be held accountable to Bexley SAB for assurances through the BSAB Embedding Learning and Assurances Framework , which is published in the Bexley SAB Annual Report.

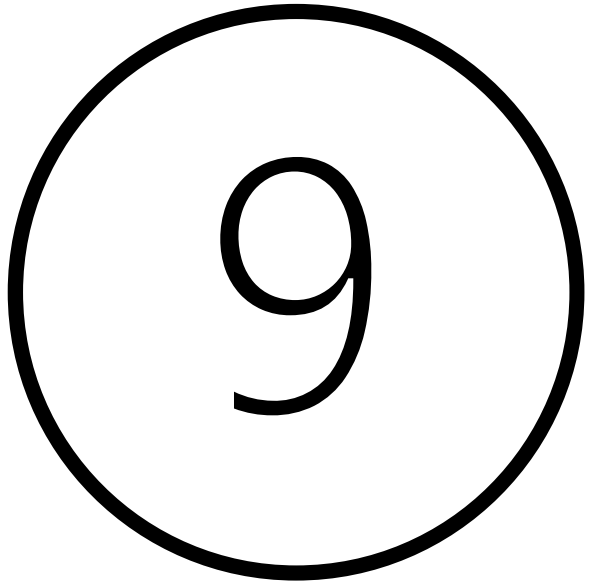
Once the Final Report has been signed-off by the BSAB Executive Members, the BSAB Business Team will feedback to the Reviewer and SAR Panel Members of the sign-off and then to the Independent Chair for BSAB oversight and scrutiny for Final sign off.



Step 9: Sharing the Learning

Once the Final Report is signed off by the Independent Chair, the BSAB Business Team will use the BSAB Embedding Learning and Assurances Framework (see Section 4), to share across the following:

- Full BSAB
- BSAB Strategic Assurances and Executive Group
- SAR Subgroup Members
- SAR Panel Members
- Director Leadership Team (DLT), LB of Bexley
- Corporate Leadership Team (CLT), LB of Bexley
- BSAB website and social media
- BSAB Learning & Development Programme
- Heads of and Managers Meeting, LB of Bexley
- Multi-Agency Learning Forum (MALF)
- Provider Forums
- Safeguarding GP Leads
- National and Regional Networks
- National SAR Library
- Any other identified forum



The expectation from s.44 of the Care Act is that the Bexley SAB and agencies involved in the SAR must embed the learning. Statutory guidance says within 6-months learning should be embedded to reduce similar incidents from happening again.

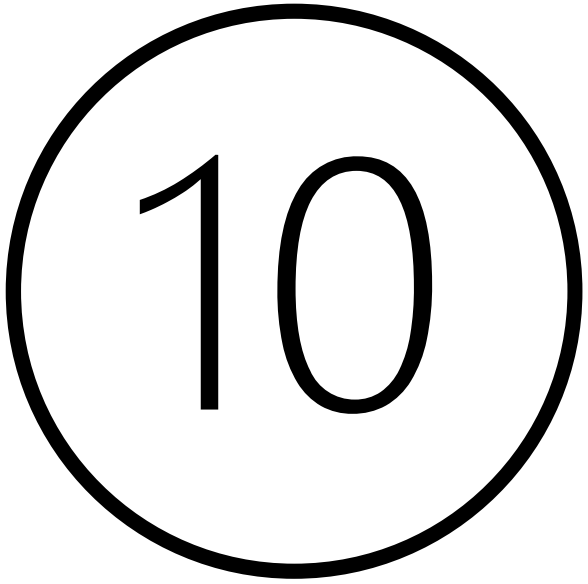
Step 10: Action Plans and Oversight

The Bexley Statutory Assurances Executive group will oversee and monitor all completed Reviews by using the BSAB Review Delivery Plan.

The BSAB uses a Thematic Action plan called Learning from Reviews Delivery Plan – all SARs will have an identified key theme; the individual SARs will not have bespoke action plans unless otherwise specified.

Any failure to complete actions will be escalated to the Independent Chair of the Board with the knowledge of the relevant BSAB Board member. Where this relates to organisation that is commissioned by the BSAB member, this will also be raised with the commissioner and regulator.

All SARs completed by the Bexley SAB are reported against in the BSAB's statutory Annual Report; all agencies will be asked to give assurances on how they have embedded the findings and acted on the BSAB Review Delivery Plan.



Embedding Learning and Assurances Framework

Independent Chair's Expectations for embedding learning across Bexley:

I am pleased to introduce this review and revised approach to learning for the SAR process. The Care Act 2014 is clear about my responsibility for the delivery of an effective and timely SAR process.

However, the purpose of a SAR is for agencies to learn and improve processes and practice. It is this responsibility for learning that needs to be at the heart of every SAR. Families and friends who contribute to the review process often state their reason is to help others learn from the tragic events that led to the loss of a loved family member or friend. It is my intention throughout my tenure as the Independent Chair of the Bexley SAB to ensure that the SAR process is built around learning and improved outcomes.

The measure of our success will be measured throughout this process and my promise to you is that I will share the positive outcomes that will emerge because of our collective efforts.

The Review(s) are completed, now what?

Now that the Review(s) is completed what happens next with all the learning?

What this means in practice :

We have allocated actions against the themes instead of each SAR having specific action plans. However, in the event, the SAR Panel and Reviewer has identified an agency to have a specific action to be held accountable then this will be recorded separately.

- All SAR Panel Members will be responsible for taking the findings back to their services, teams, and other relevant areas; including where needed commissioning, HR, and performance.
- All professionals identified with learning from Review(s) will be required to show evidence on an ongoing basis back to the Bexley SAB that they have embedded the learning.
- This will be monitored by the SAR Subgroup
- The Bexley SAB has defined Learning Pathways, Key Performance Indicators and Support to professionals to give evidence of embedding the learning.
- The Delivery Plan Actions will not be signed-off as completed until the KPIs are submitted from the named partner(s) assigned the action. These will be reported in the BSAB Annual Report, as required under s. 43, Care Act 2014.

What is a Learning Pathway?

The Bexley SAB has provided partners with a definition of What a Good Learning Pathway looks like; How to use it; and Where to go for support so that they can embed the learning from a review to their staff:

A Learning Pathway is designed to cover:

- How to move past the emotions of the findings to ensure learning.
- How to share and capitalise on Good Practice findings.
- How sometimes learning can bring professionals to feel like ‘failures’ or ‘inadequate’ the learning events will promote positive learning outcomes, not blame.
- How professionals must be encouraged to put their own biases, experiences, and past knowledge aside to adapt to new learning and development themes and actions.
- How Managers must support their staff by leading on this with themselves as well as promoting within their teams.
- How to participate in learning as the professional should be willing to engage in the learning event, whether online or face-to-face; or individual or group-based, the professional must take responsibility to take part in the learning experience on offer.
- How to promote professional learning to allow professional curiosity to be at the heart of your practice; Model this curiosity in the workplace with your colleagues and the staff that you manage; and Keep note of progress and reward positive change.

Understanding what learning is:

- A change in behaviour as a result of experience or practice; including gaining skills, knowledge and understanding new principles and concepts
- Ensuring you are able to explain the information learned to further embed knowledge, skills and understanding to others
- Applying the new information within the workplace to enhance performance
- Reveal to others how you have applied what you learned and what results you have achieved
- Nurture others by teaching them what was learned so that they too may begin to learn.

Understanding that not everyone learns the same way and that learning can be captured in many ways:

- Analysis
- Use of media
- Peer to peer challenge
- Group learning
- Individual learning

What support is available from BSAB to embed the learning:

The Bexley SAB will promote learning through the Bexley SAB Learning & Development Programme. This programme will have workshops, events and key learning forums for professionals to have access to learning.

- The events of the Bexley Learning & Development Programme specifically note the learning outcomes and what is expected on each key learning theme shared.
- The expectation is the professional will take that learning back to their service area, team, and staff to influence change.

Examples of effective embedding is Adopting the new learning principles by:

- Sharing your own challenges and ways you will change back to your teams, service area.
- Creating inclusive working environments to promote the new learning principles
- Identifying any immediate 'Easy Wins' that can be achieved to embed the learning, i.e., systems and updates to recording and where does feedback go, what is done with it, what differences are made are all good examples.
- Leading on the new learning principles by:
    - Influencing the change within your services and teams
    - Create objectives, strategic priorities and workplans to gain evidence of the learning being embedded.
    - Feedback to Bexley SAB through the use of Key Performance Indicators (KPIs) which will give evidence on what embedding looks like to yourself, your team and your service areas

Key Performance Indicators (KPIs):

Two types of KPIs, they are :

1. Quantitative indicators – show numbers for data.
2. Qualitative indicators - show what cannot be just a number but a description.

How to set KPIs: Find the learning principle and desired outcome – i.e. this plan may be a year to 3 years to implement change, but not taking action is a breach of the Care Act. Cover these core areas for each learning principle –

- Awareness – basic sharing of each learning principle
- Engagement – ensuring you and your teams are consistent with learning; i.e. ensuring you have capacity within your staffing structures to enable learning and change
- Risks to not embedding the learning principle
- Impact and Reality – how the demand for services, services commissioned and .42 conversion rates impact on safeguarding adults in Bexley
- What support is on offer for staff to achieve this new learning principle – i.e. will it be added to your mandatory list of internal training or be part of your induction process?
- Who else needs to know about the learning and implement any changes – i.e. HR, Payroll, Public, Providers?
- What do the residents of Bexley including service users, patients and other have to say about the learning principles? Do you need to do a consultation event?
- Consider commissioning new services or reviewing the ones in place – Do you need to revisit your service contracts? Do they need updating to include the new learning principle(s)?

The Bexley SAB has created the following Key Performance Indicators (KPIs) for Bexley professionals to use to show evidence of embedding Review(s) learning:

KPI 1: Evidence for Awareness :

- Number of staff informed of the new learning principle – this should be recorded by managers; for example, managers recording which team members have been informed.
- Number of staff booked onto events – this should increase when achieved
- Where did managers share the new learning principle – this should be recorded by managers; for example, team meeting minutes or emails.

KPI 2 – Evidence for Engagement:

- Number of staff attending learning events should increase – not all booked attendees show up for the events this will capture booked vs attended data.

KPI 3 – Evidence for risks identified and actions taken learning cannot be embedded:

- Partners should report back to Bexley SAB any identified risks they have found if the learning principle is not able to be embedded; for example, not providing safeguarding adults training as a mandatory requirement due to lacking time to allow staff to attend training, risk result - staff may not understand basic statutory duties and not fulfil the Care Act 2014 responsibilities.
- The Bexley SAB can assist with embedding of learning across the partnership and such escalations should be seen as a helpful discussion to assist in embedding learning; The Risks Identified may contribute towards the Bexley SAB's Risk Register (for more information on this process ask BSAB Business Team at bsab@bexley.gov.uk).

KPI 4 – Evidence to capture the support offered within your organisation to embed the learning principle(s):

- Describe what support, learning and/or training events will you provide the staff?
- Describe whether or not supervisions cover learning from Reviews and what that process looks like to embed the learning principle(s)

KPI 5 – Evidence of Impact and Reality:

- Number of service users in commissioned services
- Number of service users in commissioned services with s.42
- Number of Provider Concerns
- Number of cases where risks remain
- Case Examples on where risks to individuals have been reduced or eliminated

KPI 6 – Evidence for capturing 'Lived Experience':

- Have partners needed to amend policy and procedures? If so, which ones? How did you implement these changes?
- Have partners needed to amend commissioning contracts or statements? If so, which ones? How did you implement these changes?
- Did partners communicate the learning principle(s) with residents, service users, patients, or others about the learning principle(s)?

How will Bexley SAB monitor the KPIs?

- The Bexley SAB Statutory Assurances Executive Group will oversee and monitor the KPIs and ensure that submissions are made on-time.
- The reports will be sent to the Bexley SAB Independent Chair (IC) along with the BSAB Business Team to analyse the information and address any immediate actions required.
- The Bexley SAB IC will report six-monthly to the Full Board the KPI analyse for information, discussion and agree any actions.
- The Bexley SAB will include the KPI analysis in the Bexley SAB Annual Report.
- The BSAB should see a difference to the overall SAR thinking and process.
- The BSAB will publish in their Annual Report the outcomes from SARs.

The BSAB will use the following (as developed by Professor Michael Preston-Shoot, Emeritus Professor of Social Work, University of Bedfordshire):

Partner reactions	•Views of their experience of working with the SAB and in adult safeguarding
Changing attitudes	•Perceptions of partnerships in adult safeguarding are modified
Knowledge and skill acquisition	•Developing understanding and application in practice of procedures regarding assessment, intervention, purchaser/provider roles in adult safeguarding
Changes in practice	•Implementing new learning about adult safeguarding by the workforce
Changes in organisational behaviour	•Implementing new learning in organisational culture and procedures
Benefit to service users and carers	•Improvements in wellbeing

How will the Bexley SAB Offer support professionals to achieve learning?

The Bexley SAB produces an annual Learning & Development Programme for the entire year in advance; published each March extending until the following March.

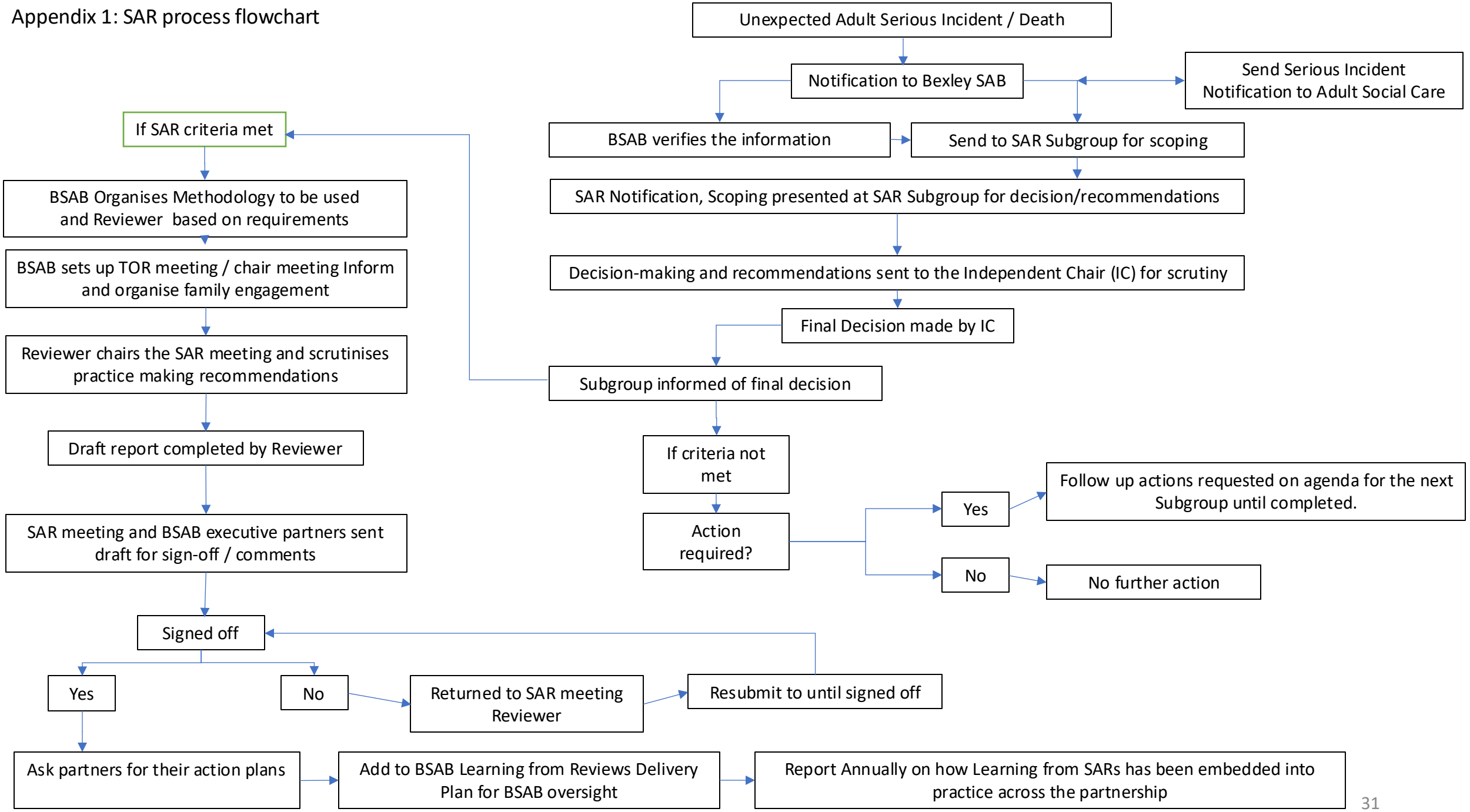
The Bexley SAB has a protected amount in the shared budget to ensure that learning events can take place across the partnership.

The Bexley SAB has an independent website where all information from Reviews, Toolkits, and other resources can be found for partners, public and others.

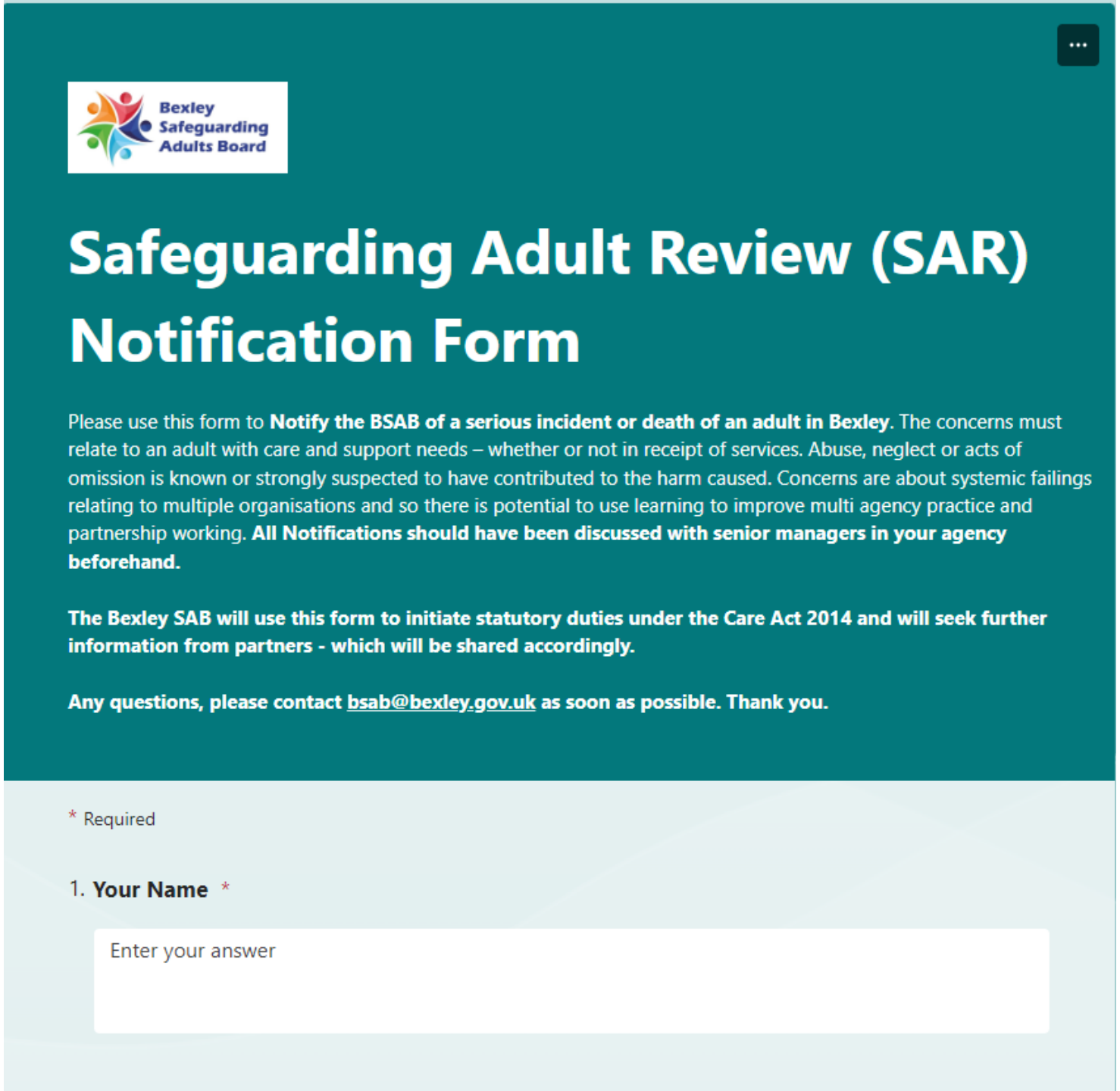
The Bexley SAB will continue to review and update its systems and processes to ensure concise, consistent, and innovative ways will be delivered.

Appendices

Appendix 1: SAR process flowchart



Appendix 2: Notification E Form



Bexley Safeguarding Adults Board

Safeguarding Adult Review (SAR) Notification Form

Please use this form to **Notify the BSAB of a serious incident or death of an adult in Bexley**. The concerns must relate to an adult with care and support needs – whether or not in receipt of services. Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused. Concerns are about systemic failings relating to multiple organisations and so there is potential to use learning to improve multi agency practice and partnership working. **All Notifications should have been discussed with senior managers in your agency beforehand.**

The Bexley SAB will use this form to initiate statutory duties under the Care Act 2014 and will seek further information from partners - which will be shared accordingly.

Any questions, please contact bsab@bexley.gov.uk as soon as possible. Thank you.

* Required

1. **Your Name** *

Enter your answer

2. **Your Email Address** *

Enter your answer

3. **Your Organisation** *

- ◯ Police
- ◯ Integrated Care System / Board
- ◯ Health (Acute, Allied or GP)
- ◯ London Borough of Bexley
- ◯ Ambulance Services
- ◯ Other

4. **What team are you from (ie. Adult Social Care, Housing, Name of Hospital)?** *

Enter your answer

5. **As a requirement, have you informed your Manager know you are making this Notification?** *

- ◯ Yes
- ◯ No

6. **Does the Adult have care and support needs as identified in the Care Act 2014?** *

- ◯ Yes
- ◯ No
- ◯ Maybe

7. **You've identified care and support needs tick all that may apply (evidence will be required later in the form) -** *

- ☐ Physical impairment or illness
- ☐ Mental impairment or illness

8. **As a result of the adult's needs, the adult is unable to achieve 2 or more of the outcomes specified below (tick all that can be evidenced as this will be required) -** *

- [ ] 1. Managing and maintaining nutrition
- [ ] 2. Maintaining personal hygiene
- [ ] 3. Managing toilet needs
- [ ] 4. Being appropriately clothed
- [ ] 5. Being able to make use of the adults home safely
- [ ] 6. Maintaining a habitable home environment
- [ ] 7. Developing and maintaining family or other personal relationship
- [ ] 8. Accessing and engaging in work, training, education, or volunteering
- [ ] 9. Making use of necessary facilities or services in the local community, including public transport, and re-creational facilities or services
- [ ] 10. Carrying out any caring responsibilities the adult has for a child
- [ ] None of the above

9. **And as a consequence, there is, or likely to be, a significant impact on the adult's well-being. ((NHS definition - Wellbeing is a broad concept and is described as relating to the following areas in particular: personal dignity (including treatment of the individual with respect) physical and mental health and emotional wellbeing, protection from abuse and neglect)). Evidence will be required.** *

- ◯ Yes
- ◯ No
- ◯ Maybe

10. **Full Name of Adult (including any aliases)** *

Enter your answer

11. **Date of Serious Incident or Death** *

Please input date (dd/MM/yyyy)

12. **Adult's Date of Birth** *

Please input date (dd/MM/yyyy)

13. **Adult's last known Address** *

Enter your answer

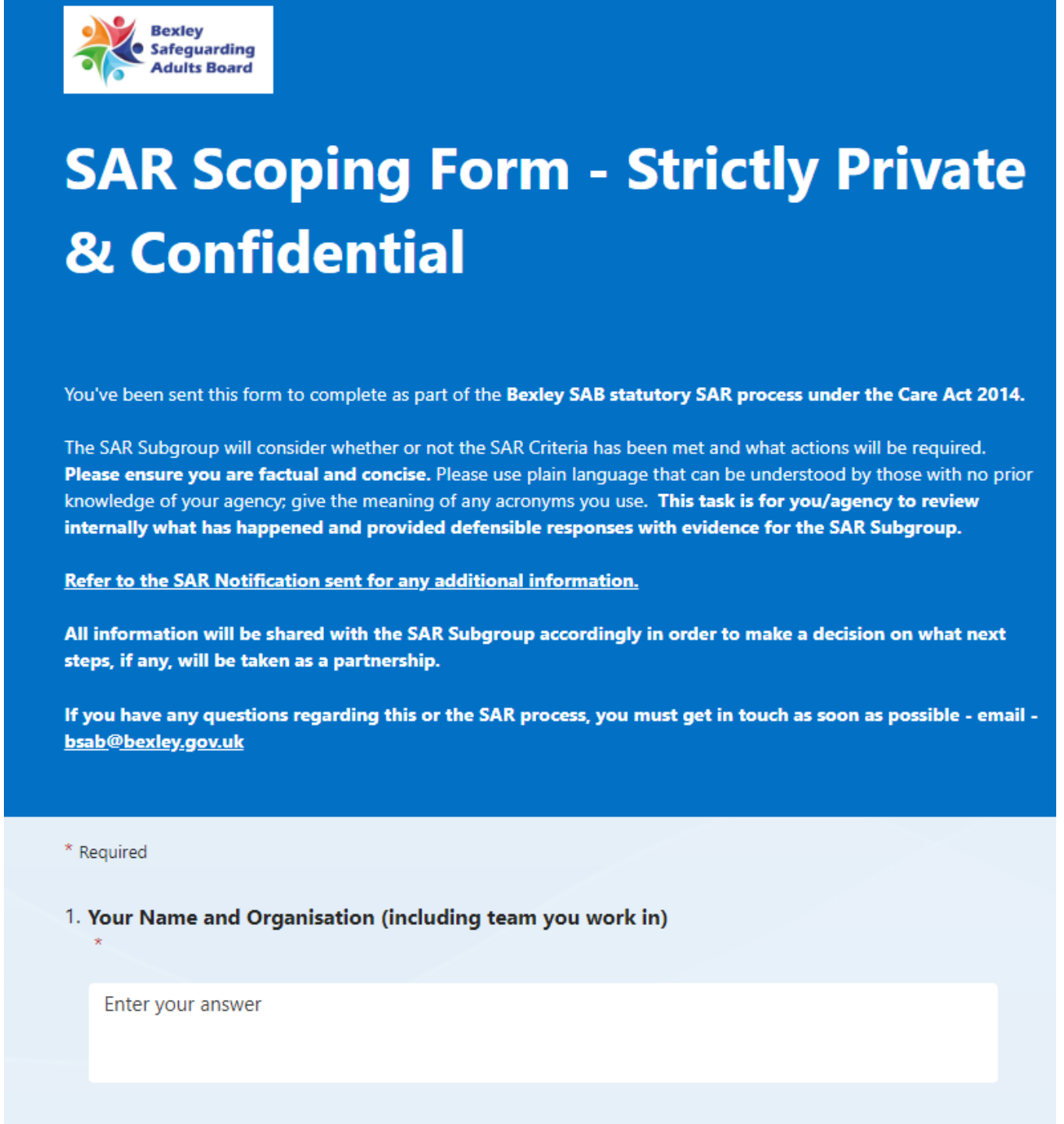
14. **Location of Incident or Death** *

- ◯ Care Home
- ◯ Supported Living
- ◯ Hospital Setting
- ◯ Own Home
- ◯ Other

15. **Summary of the Incident or Circumstances of the Death and why you think this case should be a SAR.** *

Enter your answer

Appendix 3: Scoping E Form



Bexley Safeguarding Adults Board

SAR Scoping Form - Strictly Private & Confidential

You've been sent this form to complete as part of the **Bexley SAB statutory SAR process under the Care Act 2014.**

The SAR Subgroup will consider whether or not the SAR Criteria has been met and what actions will be required. **Please ensure you are factual and concise.** Please use plain language that can be understood by those with no prior knowledge of your agency; give the meaning of any acronyms you use. **This task is for you/agency to review internally what has happened and provided defensible responses with evidence for the SAR Subgroup.**

Refer to the SAR Notification sent for any additional information.

All information will be shared with the SAR Subgroup accordingly in order to make a decision on what next steps, if any, will be taken as a partnership.

If you have any questions regarding this or the SAR process, you must get in touch as soon as possible - email - bsab@bexley.gov.uk

* Required

1. **Your Name and Organisation (including team you work in)** *

Enter your answer

2. **Name of the Adult(s) referred for SAR** *

Enter your answer

3. **Provide a brief factual and contextual summary of your agency's involvement with the adult(s) - including any Good Practice.** *

Enter your answer

4. **Were there any safeguarding adult (or children) concerns?** *

- ◯ Yes
- ◯ No
- ◯ Other

5. **What actions have you already taken to safeguard the adult(s) / children?**

Enter your answer

6. **Do you have concerns that agencies did not work to safeguard the adult(s)?** *

- ( ) Yes
- ( ) No
- ( ) Other

7. **What concerns did you have, who were they escalated to and when? Any actions taken?** *

Enter your answer

8. **Please tick all known organisations and contact details (name and email address) linked to the adult(s) and/or child(ren) to be described in next question.** *

- [ ] Local Authority
- [ ] Hospital
- [ ] Police
- [ ] GP
- [ ] School/College
- [ ] Mental Health Services
- [ ] Ambulance Services
- [ ] Other

9. **Describe how those agencies are involvement below.** *

Enter your answer

10. **Is there anything else the BSAB should be made aware of to consider as part of this Scoping for the Decision Making at the SAR Subgroup?** *

Enter your answer

11. **Section 3: – Sign-off**

I confirm that this is an accurate Summary of Involvement prior to returning to the Safeguarding Adults Board

Name is Signature

Job Title

*

Enter your answer

Appendix 4 :
Decision Making Form

SAR Decision Making form

BSAB Case Number:		
Date presented to SAR Subgroup:		
Summary of Final Recommendation by SAR Subgroup: (Circle one)	Yes	No
Date agreed by Independent Chair:		
Notification sent by: Confirmed that the Adult has Care & Support needs – see Notification Form		
Have there been any parallel reviews, investigations and/or enquires to this case?	Yes- what one?	No

Because the adult has care and support needs - Section 44 Care Act Safeguarding Adult Review Duty must be considered. **Note: YES or NO answers only.**

Agency / Representative	Yes or No	Rationale - Agency to explain why they believe s.44 Care Act has been met	Is it linked to an existing SAR? How?	Type of SAR recommending: 1. Significant Event Analysis or Audit 2. Systems Review 3. Using Individual Management Reviews to Analyse Individual Agency Performance 4. Multi-agency Combined Chronology Traditional Serious Case Review, using a Combined Chronology, Individual Management Reviews and a Review Panel	Early Themes identified 1. Domestic Abuse 2. Making Safeguarding Personal - Reluctance to Engage 3. Trauma-Informed Practice 4. Mental Capacity in relation to Executive Capacity/Crisis/Duress/Inherent Jurisdiction 5. Person-Centred Planning / Crisis Planning / Strengths-based 6. SAB Governance / BSAB role in Improving Practice - Training & Awareness Raising / SAR Process 7. Information Sharing / Inter-Intra Agency sharing / Information Recording Systems / Record Sharing / Information Flow / Record-keeping 8. Record Keeping 9. Suicide Awareness 10. LA Oversight / Governance 11. Think Family 12. Safeguarding Literacy and Knowledge / Professional Curiosity, Professional Roles & Responsibility / Safeguarding Processes 13. Assurances 14. Risk Assessment / Visiting Individuals at Home where possible 15. Organisational Policy/Procedures / Organisational Practice Silos / Information System Structure Silos 16. Information to Regulator 17. Homelessness/Housing Services/Impact on Individual and Family 18. Assessing And Meeting Needs - Safeguarding Action – Referral & Response / Risk Awareness & Assessment; Working with Families And Significant Others / Responding to Characteristics of The Individual 19. Practitioner Attributes - Including Legal Literacy, Mental Capacity 20. Case Co-Ordination / Failure to Engage a Multi-Agency Approach / Leadership / Use of Multidisciplinary Meetings And Complex Case Management Frameworks 21. Lack / Shortage of Services - LA Housing stock, commissioned services 22. Workload Pressures / Staffing / Supervision and Support / Management Oversight and Leadership 23. Carer's Support and access to help as a Carer	What type of review/reviewer are we recommending? 1. Learning Brief for rapid embedding 2. Independent Reviewer & Author – what skills do they need to have?	Who will represent at the Terms of Reference Meeting for the review if commissioned?
Local Authority – ASC							
Local Authority – Housing							
Integrated Care Board – Bexley							
Metropolitan Police Service							
Lewisham Greenwich Trust							
Dartford Gravesham Trust							
National Probation Services							

Was there any Good Practice Identified? Describe below:

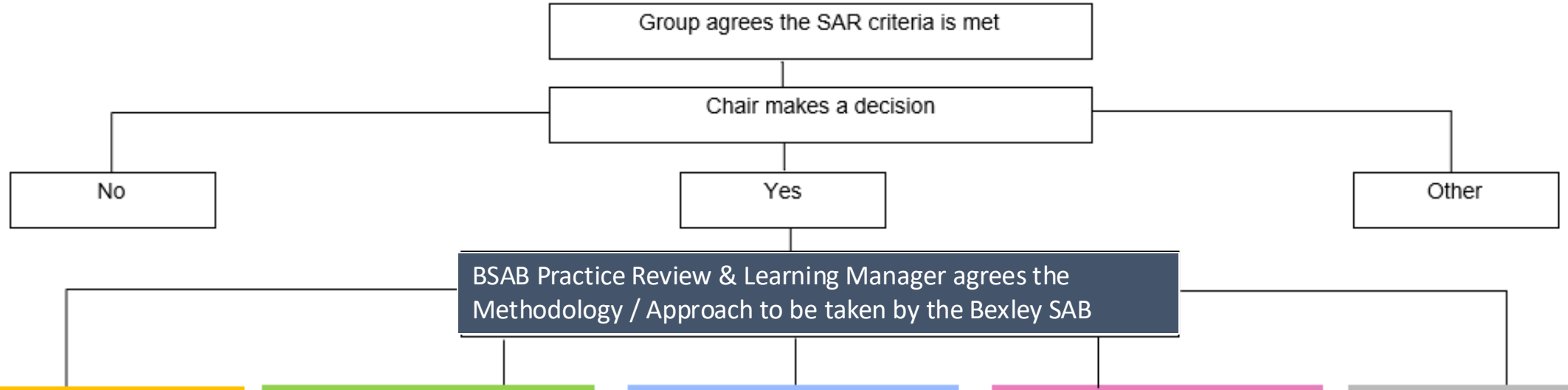
Agreed Next steps:

1. Refer to BSAB Independent Chair for scrutiny and oversight Independent Chair makes a decision: -
   - whether identified Early Learning Themes are within the last 12-months and can be linked to completed Bexley SARs;
   - what type of SAR they are commissioning using the BSAB SAR Methodology Tree (see Appendices); and
   - what type of Reviewer they want to commission, some options are: –
     - Commission an Independent Reviewer and Scrutineer; or
     - Commission a Local Reviewer and an independent Scrutineer; or
     - Commission a Local Reviewer with them as the Independent Scrutineer; or
     - Commission themselves as the Independent Reviewer and Scrutineer.
   - Any urgent safeguarding actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review;
   - Working with relatives and/or the individual involved (where death has not occurred and when appropriate); and
   - And seek any information that will give the BSAB assurances that learning is being embedded in Bexley.

2. Independent Chair notifies the SAR Subgroup and Full SAB

3. Commission a reviewer - Terms of reference meeting to be booked by BSAB Business Team

Appendix 5: SAR Methodology Tree



1.Significant Event Analysis or Audit

This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.

A learning brief is a good example of this being done as a quick time learning event. Which will be sent to BSAB SAR Subgroup for sign off and then to the Independent Chair for final sign off. The Learning Brief will be prepared by BSAB Practice Review & Learning Manager as the Reviewer. When this method is agreed.

2.Systems Review

The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.

This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice.

It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

3.Using Individual Management Reviews to Analyse Individual Agency Performance:

Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced.

Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.

4. Multi-agency Combined Chronology:

Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.

5. Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel:

It maybe that the Sub Group considers that the best way addresses a complex case if for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding.

1. Significant Event Analysis or Audit
 	
This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development.
	The process followed in a Significant Event Analysis or Audit is as follows:
	
	• Information Gathering – collation of as much factual information about the event as possible from a range of sources.
	• Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment.
	• Analysis of the Significant Event: The key questions that require answering in a Significant Event Analysis or Audit are:
	  o How could things have been different?
	  o What can be learned from what happened?
	  o What has been learned?
	  o What has been changed or actioned?

2. Systems Review The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice. It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.	**A systems approach to conducting a Safeguarding Adults Review involves:** • 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 presiding 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 the BSAB; 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 learned and recommendations • Event to consider first draft of the overview report and action plan • Final overview report presented to BSAB, agree dissemination of learning and monitoring of implementation • Follow up event to consider action plan recommendations • On-going monitoring via the BSAB.
3. Using Individual Management Reviews to Analyse Individual Agency Performance: Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced. Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.	Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model. Most popular methodology used – more information in Appendix 3 of the SAR Toolkit.
4. Multi-agency Combined Chronology: Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.	Chronologies are important tools that are particularly useful when combined across agencies using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.
5. Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel: It maybe that the Sub-Group considers that the best way addresses a complex case if for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding.	This method will provide a detailed analysis of agencies' work with an adult or group of adults and provide a familiar approach to learning; the SAR Sub-Group will give very careful consideration to any added value achieved through this approach. Safeguarding Adults Reviews are resource-intensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

Safeguarding Adults Review – Case X
Terms of Reference

1.Background & Context -

2. Meeting the SAB duty to conduct a Safeguarding Adults Review

2.1 The BSAB will take the lead for conducting a SAR when:

- An adult at risk dies and abuse or neglect is known or suspected to be a factor in their death
- An adult at risk has sustained any of the following: a life threatening injury through abuse or neglect; serious sexual abuse; serious or permanent impairment of development through abuse or neglect

OR

- Where there are multiple victims
- Where the abuse occurred in an institutional setting
- A culture of abuse was identified as a factor in the Enquiry

AND

- The case has given rise to concerns about the way in which local professionals and services worked together to protect and safeguard the adult at risk

The Purpose of a SAR

In accordance to the Care Act 2014, and the associated statutory guidance, the purpose of this SAR is to:

a) establish lessons to be learned from the case of C, in terms of how professionals and organisations worked, both individually and together, to safeguard the adult at risk and prevent harm

b) identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems

c) deploy a mechanism for the BSAB to apply lessons learned to service responses for adults at risk across Bexley and to share these lessons at a national level

3. SAR Management

4. SAR Methodology

5.Agencies who will/have been be asked to submit IMR reports

6. Action to be taken if there is a failure by agencies to co-operate with a SAR request

7. Specific Issues to be Addressed

8 Information sharing and confidentiality

- 8.1 Previous Safeguarding Adult Reviews
- 8.2 Particular issues relating to ethnicity, disability, sexual orientation or faith
- 8.3 Known research that may contribute
- 8.4 Participation of the Family

9. SAR Governance

10. Period the Safeguarding Adults Review will cover and report completion

11. Parallel Processes

12. Media Strategy

13. Legal Advice

14. Attendance and Agreement

Appendix 7: SAR Letter To Family Template

Date

Dear

PRIVATE and CONFIDENTIAL

Safeguarding Adults Review -

Invitation to be involved in an Independent Safeguarding Adults Review

I am writing on behalf of the Bexley Safeguarding Adult Board as we were given your name(s) as the who sadly died, in . Please accept our belated condolences.

The purpose of my letter is to invite you to participate in an Independent Safeguarding Adult Review (SAR) commissioned by the Bexley Safeguarding Adults Board, which we are calling to keep anonymity. I have included the BSAB SAR Leaflet that explains the statutory duties of the board and how you can engage if you wish to do so.

In short, The Care Act 2014 requires local agencies to learn lessons from how they supported and during the review agencies will need to update the Reviewer that they have identified learning. On occasion, the Reviewer and the Review Panel (agencies involved) may highlight concerns, which will be highlighted to the appropriate teams to seek assurances that the welfare of any adult(s) or child(ren) are not at risk.

As part of this invitation, it is important for you to identify who the family of is and who the family will give permission or decline to engage in the review.

The Bexley Safeguarding Adults Board has appointed an Independent Reviewer, to lead this review. The independence of the Reviewer is to ensure that this Review is done both fairly and impartially according to government guidance.

Lucy would like to meet with some relevant staff who were involved in supporting Lorraine and if you choose to engage in the review, your identified family representative(s) to hear your point of view. You can have a friend or advocate with you when if you agree to meet with them. If you think any other family members would wish to talk with the Reviewer, please pass this invitation on to them.

It is our hope that you will meet with so that your views about how services worked with, so that we can also learn directly from you.

If you wish to contact Lucy, please email me at bsab@bexley.gov.uk, where I can assist in organising a suitable time and arrange to meet (under Covid we are holding most meetings online). Thank you for your time and we look forward to hearing from you.

Yours Sincerely,

Anita Eader, Practice Review & Learning Manager

Media Template

'IF ASKED' BSAB STATEMENT – OPTION 1

Safeguarding Adult Review (SAR) – DATE

We wish to express our deepest sympathy to the family and friends of SARX, who tragically died in YEAR.

Bexley's Safeguarding Adult's Board (BSAB) and the Safeguarding Adult Review (SAR) panel would like to thank SARX's family for their participation in the review, which has informed report that has been published DATE. Family engagement in the process is so important in helping statutory agencies to identify learning associated with SARs.

The SAR process, which brought together all relevant agencies, began in MONTH YEAR. It was chaired by an Independent Reviewer to help identify learning and write the final report.

There has been a range of learning from the review and a number of recommendations. These will be implemented and monitored through the SAR & Learning Subgroup with partner agencies, and reported back to the BSAB, with all agencies seeking to bring about preventative changes for adults in Bexley.

Anyone in need of support should contact CRUSE (bereavement services) freephone 0808 808 1677-The helpline is open Monday-Friday 9.30-5pm (excluding bank holidays), with extended hours on Tuesday, Wednesday and Thursday evenings, when we're open until 8pm, Friday.

ENDS

‘IF ASKED’ BSAB STATEMENT – OPTION 2

Bexley’s Safeguarding Adult’s Board wishes to express its sympathy to SARX family.

The safeguarding and protection of adults in Bexley is a priority for agencies involved in their welfare. It is a responsibility each agency takes very seriously.

As is standard practice when an unexpected death or serious injury of an adult occurs, a Safeguarding Adult Review (SAR) has taken place by the BSAB.

The SAR report provides a sound analysis of what happened in the case and makes recommendations for action and learning. The review findings have been actioned by the agencies involved and progress is closely monitored by the Bexley Safeguarding Adult’s Board.

The overview report has been published here/at www.safeguardingadultsinbexley.com

ENDS

BSAB 'HOLDING' STATEMENT – OPTION 1 - ISSUED BY LBB ON BEHALF OF THE BEXLEY SAFEGUARDING ADULT'S BOARD

Bexley's Safeguarding Adult's Board (BSAB) would like to express our sympathy to the family of SARX at this very difficult time.

The safeguarding and protection of adults at risk in Bexley is a priority for agencies involved in their welfare. It is a responsibility each agency takes very seriously.

As is standard practice when an unexpected death or serious injury of an adult occurs, a Safeguarding Adult Review (SAR) may take place by the BSAB.

In line with the government's Care Act 2015 regulations, the report provides a sound analysis of what happened in the case and looks at the actions and learning put in place by agencies in response to the review findings and the impact these actions have had on improving services.

We are unable to make any further comment at this stage.

ENDS

Notes for editors –

Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs). This resource aims to help SABs in thinking about how they fulfil those responsibilities. It focuses on a selection of key issues. It is intended to supplement the policy development work already underway or completed by SABs.

The Care Act 2014 states that BSAB's must conduct any Safeguarding Adults Review (SAR) in accordance with Section 44 of the Act.

For more information on SARs, visit www.safeguardingadultsinbexley.com

Appendix 9:
SCIE SAR Quality Markers

Safeguarding Adults Review Quality Markers

Safeguarding Adult Review (SAR) Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs.

The Quality Markers are based on statutory requirements, established principles of effective reviews and incident investigations, as well as practice experience and ethical considerations.

The SAR Quality Markers assume the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountable). These principles therefore permeate the Quality Markers explicitly and implicitly.

Introduction to SAR Quality Markers

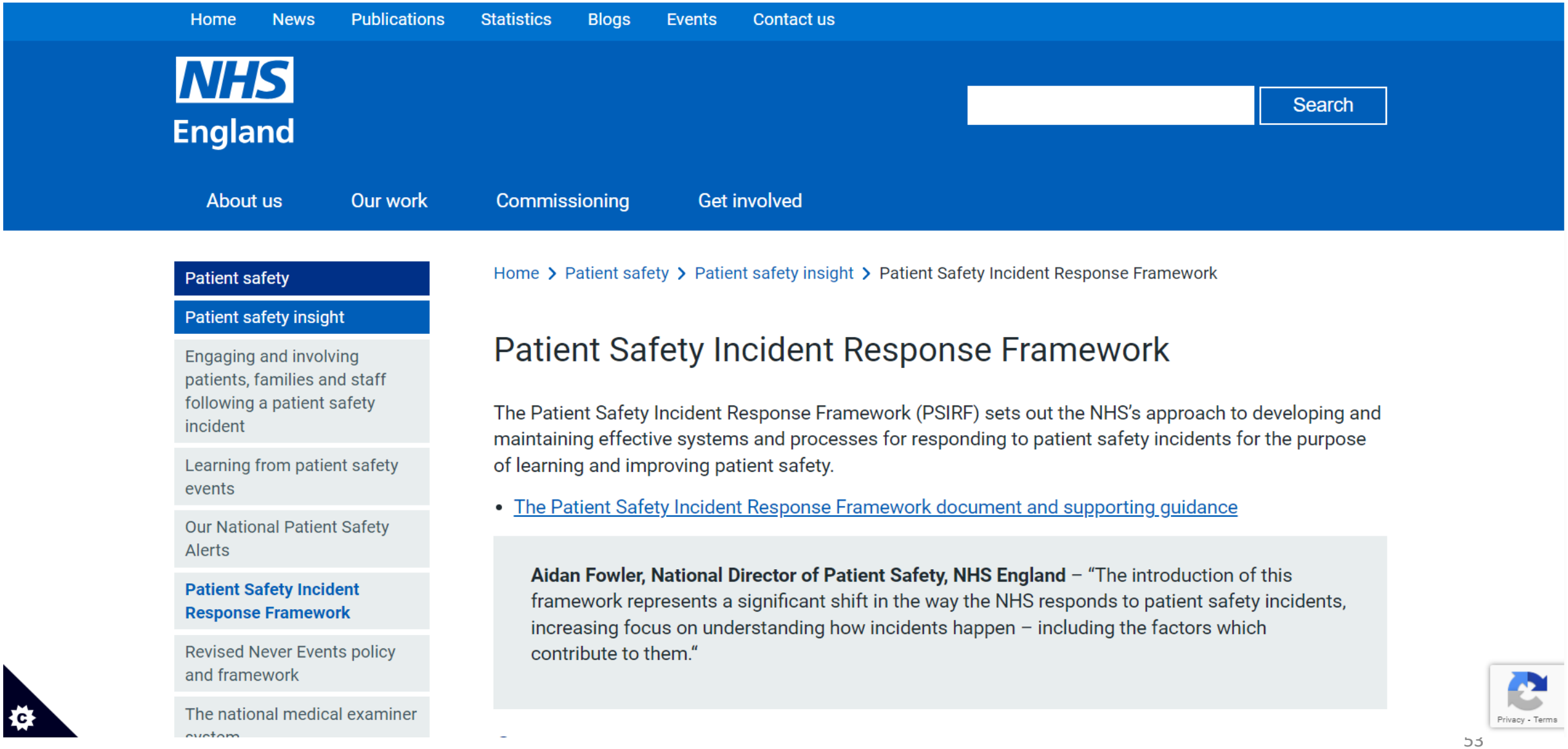
SCIE is pleased to relaunch the Safeguarding Adult Review (SAR) Quality Markers. First published in 2018, they have now been refreshed and updated.

Find out more →

View list of the 15 SAR Quality Markers →

Appendix 13: NHS Patient Safety Incident Response framework

NHS England – [Patient Safety Incident Response Framework]



LeDeR

LeDeR is a service improvement programme for people with a learning disability and autistic people.

Established in 2017 and funded by NHS England and NHS Improvement, it's the first of its kind. LeDeR works to:

- improve care for people with a learning disability and autistic people
- reduce health inequalities for people with a learning disability and autistic people
- prevent people with a learning disability and autistic people from early deaths

LeDeR reviews

A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. We look for areas that need improvement and areas of good practice. We use these examples of good practice to share across the country. This helps reduce inequalities in care for people with a learning disability and autistic people. It reduces the number of people dying sooner than they should.
So far, we've completed over 9000 reviews. We have found out lots of information and learning on the best way to carry out these reviews. We use the data and evidence to make a real difference to health and social care services across the country.

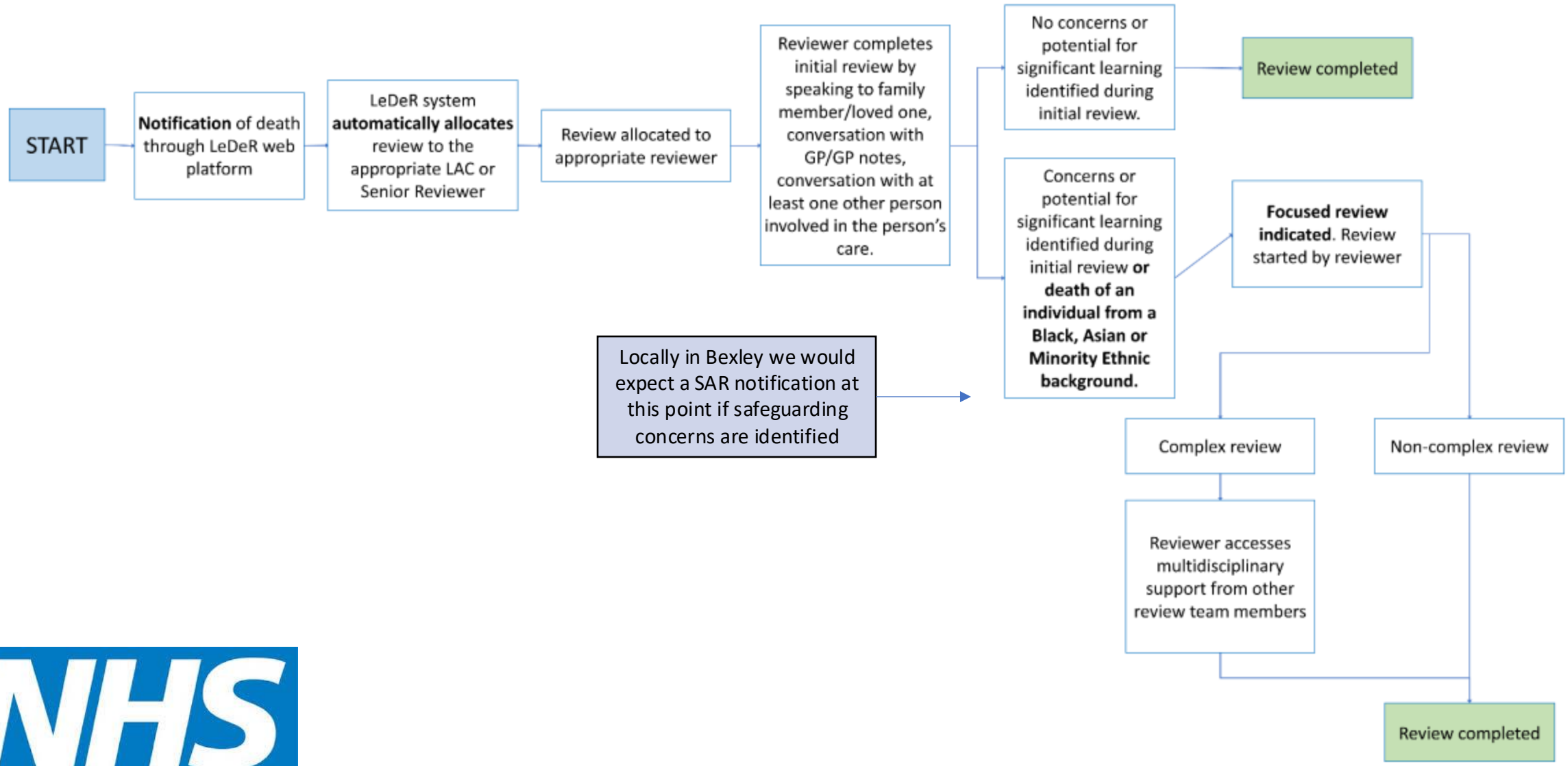
How LeDeR fits with existing local and national reviews of deaths

There are several different review processes for people who die. For example:

- child death review
- safeguarding adults' review
- review of deaths of people in hospitals

If this is the case, we will work together to try to avoid unnecessary duplication. Reviewers will make it clear to familieswhere and how the LeDeR process links with other reviews or investigations.

LeDeR Review Process Overview



DHR protocols

Parallel Statutory Reviews/Pathways - DHR: A SAR may be referred even if another statutory review has already been commissioned. The Independent Chair must decide on whether to proceed. The referral still needs to be made. It is not up to a single agency to decide what gets referred or not.

- Domestic Homicide Reviews (DHRs): Where a situation is being considered as a Domestic Homicide Review (DHR) and the case involves an adult at risk of abuse or neglect, the Community Safety Partnership will automatically refer the case to the BSAB for consideration as a SAR.
    - This will be referred to the SAR Subgroup, but that Subgroup will consider recommendation to the BSAB Chair:
        - a SAR led by the BSAB should be undertaken
        - a recommendation to the DHR with adult safeguarding involvement should be made OR
        - where a decision has already been made for a DHR, a joint review should be undertaken

Coroner's Court

The Coroner: Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody (including DOLS), which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk.

The National SAB Guidance on the Interface between SARs and Coronial Processes was published on 22nd July 2024. To view this in full **click here**.

These are likely to fall within one of the following categories where:

- Obvious and serious failing by one or more organisations;
- No obvious failings, but the actions taken by organisations require further exploration/explanation;
- A death has occurred and there are concerns for others in the same household or other setting; **OR**
- Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries/actions are identified by the Coroner or his or her officers.

NOTE: If HM Coroner contacts the BSAB and/or its partner(s) about any of these situations, the SAR Subgroup Chair must be informed through the Notification Form to the BSAB Working Team as per usual pathway for SAR consideration.

Safeguarding Practice Reviews

Children's Safeguarding Practice Reviews (previously known as: Serious Case Reviews (SCR)):

It may be that the Bexley Local Children's Safeguarding Partnership Board also conducts a review or is involved in the DHR and/or SAR a key partner to the BSAB or a jointly commissioned SAR may be decided on between Chairs of the LSCB and the BSAB and not in isolation nor by a single agency.

Protocol for Conducting Joint Statutory Reviews

Bexley Safeguarding Adults Board

Bexley SHIELD Safeguarding Children's Partnership

Bexley Community Safety Partnership Board

[Click here to read the Protocol in full]

For more information contact: -

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