Hillingdon Safeguarding Partnership

Adult Serious Incident Process

1. Context

1.1 Hillingdon Safeguarding Partnership is a joint arrangement across the adult and child safeguarding networks. In September 2019, the Hillingdon Safeguarding Children Partnership was launched in line with the statutory requirements set out in the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018. Following the successful implementation of the new statutory arrangements for children, the same approach was applied to the Safeguarding Adults Board (SAB) to meet the Local Authorities duties under the Care Act 2014. This has enabled Hillingdon to provide a safeguarding service that is consistent, irrespective of age, and provides opportunities for innovative and responsive services in the Borough. Under both these arrangements the Local Authority shares responsibility with statutory partners: the NHS North West London Clinical Commissioning Group and the Metropolitan Police.

1.2 The Hillingdon Safeguarding Partnership is committed to the development of a learning culture that:

- is open and honest
- is proportionate and avoids hindsight bias
- identifies and addresses systemic practice issues
- supports and challenges safeguarding partners to make continuous improvements to practice

1.3 This document is concerned specifically with arrangements and processes in place to respond to serious incidents, specifically those in which an adult believed to have care and support needs has died or is believed, or suspected, to have suffered serious abuse or neglect.

1.4 This process does not apply to a death by suicide unless there is also a belief or suspicion that serious abuse or neglect occurred. Please refer to section 6 below for details on the process to follow where there has been an attempted or completed suicide.

1.5 The Care and Support Guidance states that the main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. A key SAB duty is to conduct any Safeguarding Adult Reviews in accordance with Section 44 of the Care Act 2014. This is further explained in section 4 below.

1.6 Arrangements and processes to enable the SAB to discharge its statutory duties in response to serious incidents includes the policies, procedures and systems in place to respond timely to safeguarding adult concerns as they arise, to ensure timely interventions to safeguard adults at risk, including the adult concerned in the serious incident and any other adults at risk.

2. Notification of a Serious Incident

2.1 All members of Hillingdon SAB are required to notify the Safeguarding Partnership Team of a situation that might meet the criteria for a SAR. As the lead agency for safeguarding adults it is anticipated that adult social care will be the primary source of referrals to the SAR Panel. Where another agency wishes to highlight a case for consideration, they can do so through completing a multiagency Need to Know form. Hillingdon Adult Social Care have developed an internal Need to Know Process for this purpose (Appendix 1).

2.2 All members of Hillingdon SAB are also required to refer the serious incident to the Multi Agency Safeguarding Hub within the Local Authority via Social Care Direct. This is because the Local Authority is the lead agency in relation to Safeguarding Adults and has a duty under Section 42 of The Care Act 2014 to carry out enquiries if it has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) —

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

3. Multi Agency Safeguarding Hub Processes

3.1 Adult MASH will undertake timely information gathering and sharing for the purposes of informing risk assessment and management actions and to establish whether the criteria for s.42 are met in respect of the adult. This includes gathering the views of the adult at risk, where practicable and safe, and sharing information with the adult and/or relevant other individuals.

3.2 Adult MASH will share information with relevant agencies e.g. CQC, London Borough of Hillingdon Quality Assurance, North West London Clinical Commissioning Group (CCG), Central North West London (CNWL) NHS Foundation Trust (including Community Health, Hillingdon Mental Health, and Addictions), The Hillingdon Hospitals NHS Foundation Trust, Housing provider (if known), Community Safety Team etc.

3.3 Where relevant, agencies are responsible for commencing their own Independent Management Reviews/Serious Incident Investigations/internal investigations and for taking any immediate action required related to their organisation. The intention to complete such investigations should be shared with Adult MASH to inform partnership risk assessment and management plans.

3.4 Adult MASH will share information with the Police if a crime is suspected to have occurred. There is a daily high-risk meeting that is attended by MASH representatives and will enable the timely identification of cases where a police response may be required. Partner organisations should also ensure timely reports to the police of suspected crimes and

make Adult MASH aware of such action at the earliest opportunity to inform partnership risk assessment and management plans and avoid duplication. All safeguarding partners have a duty to ensure that crimes are reported to the police as soon as they are identified.

3.5 Adult MASH will lead on a risk assessment related to any others who may be at risk, e.g. children or any other dependants, a carer or if the person alleged to be responsible for the abuse or neglect is a carer or working/volunteering with any other children or adults. This may be explored in the Adult MASH 12pm daily meeting. Examples of actions following this risk assessment may be as follows: suspension of an employee, the provider/organisation/service commences an investigation into the incident, the Provider Concern process for provider/organisation/service is commenced, referrals are raised with Children's MASH, LADO or Adult LADO as required, as outlined in the ADASS London Multi-Agency Adult Safeguarding Policies and Procedures

3.6 Adult MASH will complete a Need to Know form (Appendix 1) and this is sent to the Head of Service for Safeguarding Adults, Adult Social Care. This will reflect risk assessment and management actions taken that are known to Adult MASH and all relevant information already gathered.

3.7 The Head of Service for Safeguarding Adults will review the Need to Know form and share this with any relevant Head of Service in Adult Social Care and any other partnership organisation e.g. the North West London CCG, The Hillingdon Hospital, Police or CNWL to explore/agree any further action required related to operational processes or staff member conduct or capability, and refer to the Provider Risk Panel if needed. Where appropriate the Adult Lado process will be implemented.

3.8 Following review by the Head of Service for Safeguarding Adults a copy of the Need to Know form will be sent to the Safeguarding Partnership to establish if an immediate referral to the SAR Panel is required or if the Need to Know should be recorded as "For information only" pending the outcome of enquires. The Head of Service for Safeguarding Adults maintains a spreadsheet of completed "Need to Know" forms with related activity recorded.

3.9 If an adult dies and there are concerns of manslaughter, attempted murder, murder or provider issues, concerns can also be explored immediately through Gold meetings and/or the Provider Concern Process, as outlined in ADASS Multi Agency Adult Safeguarding Policy and Procedures.

3.10 By exception, where a serious incident has occurred, senior managers can convene, and a referral can be made for consideration at SAR Panel.

3.11 If the concern progresses to Section 42 Enquiry under The Care Act 2014, ADASS London Multi Agency Adult Safeguarding Policy and Procedures will be followed. It is recommended that a separate resource is secured to carry out any Safeguarding Adult Enquiry relating to a serious incident, and/or there are concerns related to the practice of Adult Social Concern staff/policies and procedures related to Adult Social Care.

3.12 The Section 42 Enquiry documentation will be finalised at multi agency safeguarding adult round table meeting with any dissent to outcomes/recommendations recorded.

3.13 Enquiries pursuant to section 42 should be completed in 40 days (with some flexibility, taking Making Safeguarding Personal into account). Such enquiries should be proportionate and can cease at any time if considered appropriate and agreed with the relevant Head of Service.

3.14 The multi-agency meeting decides if a referral needs to be made to the SAR Panel if the criteria for a SAR is believed to be met or there is a need to consider further systemic, organisational or cultural learning.

3.15 If the threshold for a referral to the SAR Panel is not believed to be met, a summary of the recommendations and outcomes are sent to the Safeguarding Partnership so trends and themes can be collated to inform practice development.

4. Duty to carry out a Safeguarding Adult Review (SAR)

4.1 The Care Act (2014), Section 44 outlines the following -

- 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 other persons with relevant functions worked together to safeguard the adult, and
    b. condition 1 or 2 is met.

- 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).

- 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.

- 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).

- 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.

4.2 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. SABs are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support. (Care and Support Statutory Guidance, 2014)

4.3 As outlined above, the SAR Panel should consider whether to undertake a discretionary SAR under section 44(4) when the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of adults, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of adults
- Where there has been no agency involvement, and this gives the safeguarding partners cause for concern
- Where more than one local authority, police area or clinical commissioning group is involved, including in cases where adults have moved around
- Where the safeguarding partners have cause for concern about the actions of a single agency
- Where the case may raise issues relating to safeguarding or promoting the welfare of adults in institutional setting

5. Safeguarding Adult Review Panel

5.1 The SAR Panel is a multi-agency senior officer group with delegated responsibility from the Hillingdon SAB. The SAR Panel reviews serious incidents notified to the Safeguarding Partnership and decides if the criteria for a statutory SAR are met or whether a discretionary SAR or other learning activity is required.

5.2 The SAR Panel will seek to identify systemic, cultural and organisational learning from serious incidents to continuously improve safeguarding practice and multi-agency working. The Panel will consider how learning from serious incidents can be used to inform understanding of the strengths and areas for development in our partnership safeguarding systems. It will adopt a think family approach to enable learning and development to be coordinated across children and adults as appropriate.

5.3 It is recognised that effective safeguarding work is complex and includes the contribution of a network of professionals and agencies. On this basis learning can be identified for individual safeguarding partners but is likely to have applicability across the wider partnership.

5.4 SAR Panel arrangements:

Core membership will be as follows:

- Head of Service Safeguarding Adults - Adult Social Care
- Police Superintendent or designated deputy
- North West London CCG Safeguarding Adults Lead
- CNWL Safeguarding Lead
- Safeguarding Adults Lead - The Hillingdon Hospital
- Safeguarding Partnership Manager

Where required the following will also be available to attend:

- CNWL - Mental Health Lead
- CNWL – Community Health Lead
- London Borough of Hillingdon – AMHP Lead
- London Borough of Hillingdon - Children's Social Care
- London Borough of Hillingdon - Housing Department
- Any other agency by invitation

5.5 The chair of the panel will be a statutory partner i.e. a representative from the Local Authority, the Clinical Commissioning Group or the Metropolitan Police. The Panel will be convened monthly with the following agenda:

- New referrals
- Cases for formal consideration
- Review of previous actions

5.6 Referrals to SAR Panel will be reviewed by the Panel Members, and a decision made to add to the agenda for formal consideration the following month. The panel representative for each member agency is then responsible for ensuring the timely availability of information from their agency at least one week prior to the scheduled discussion. The Safeguarding Partnership Team will be responsible for seeking information from any agency that is not represented at SAR Panel.

5.7 Each Panel member is responsible for ensuring the timely completion of the Information and Scoping template. This ensures that key chronological information is provided, with an analysis of single agency and multiagency practice.

5.8 All completed templates should be shared with Panel Members to review before the meeting. If an agency wishes to share a full single agency led investigation or internal management report, they may choose to do so but must also ensure that the scoping document is completed to provide a summary and analysis. Circulation of agency information can be coordinated by the Safeguarding Partnership Team if the information is provided at least one week before the Panel date. Where an agency does not provide this information the relevant Panel representative is responsible for ensuring that information is circulated to other Panel members. Attendees should read all documents before the meeting to understand agency involvement and any areas of learning, development, and good practice to be discussed at the panel.

5.9 The members of the SAR Panel and ultimately the chair of the SAR Panel, are accountable for the decision reached. The decision of each SAR Panel member will be recorded in the

minutes. It is anticipated that in most circumstances an agreed decision will be reached. Where this is not possible the case can be escalated to the Chair of the Safeguarding Adults Board, and to the Executive Leadership Group by exception.

5.10 There are a range of possible SAR Panel outcomes -

- If section 44 Care Act criteria are met a Safeguarding Adult Review will be commissioned by the SAR Panel.
- The Panel may also identify the need for a discretionary SAR where the statutory criteria are not met, but it is identified that a review of the case would aid understanding of local practice.
- A thematic SAR can be commissioned if it is considered necessary in response to recurrence of particular issues.

5.11 The Panel will choose the most appropriate and proportionate model. The Panel will be responsible for ensuring that any SAR is concluded in a timely manner and in line with the SAR Quality Markers to strengthen governance and ensure best practice in relation to commissioning, conducting and quality assuring SARs. SAR Panel will record any reasons for delay in the completion of SARs. (Please see Appendix 3 for a copy of the SAR Quality Assurance Markers).

- Dependent upon the specific case circumstances a SAR can be led by the Safeguarding Partners, or an independent author commissioned.

- Where there is an ongoing parallel process, for example a Learning Disabilities Mortality Review (LeDer), this will be incorporated into the wider Partnership response to the case.

- Where areas of multiagency learning are identified, these will be passed to the Practice Development Forum to co-ordinate actions and disseminate learning as appropriate. The Practice Development Forum will also coordinate any non-

statutory learning reviews. The Practice Development Forum also receives learning related to reviews of children's cases, therefore, the "Think Family" approach and learning across children and adults is coordinated here.

- "SARs in Rapid Time" are part of The Department of Health and Social Care's COVID-19 Action Plan for Social Care. The Covid 19 pandemic resulted in pressures on staff's capacity to participate in reviews. However, the need for rapid identification and sharing of learning stands. The "SARs in Rapid Time" model aims to have a completion time of 15 days but a completion time of 6 weeks is felt to be more reasonable. This mirrors the Children's Rapid Review Model but unlike the Children's Rapid Review Model, there is no statutory requirement to report to a national panel but there is a requirement to feed outcomes and recommendations into the national SAR library.

6 Resolving Professional Differences

6.1 Where there is a difference in professional opinion regarding the outcome of a serious incident consideration agencies should write to the Chair of the SAR Panel. The Chair will review the decision-making process and communicate the outcome of this review to the agency concerned. Where professional differences remain, these can be escalated to the Chair of the Safeguarding Adults Board and subsequently to Hillingdon Executive Leadership Group.

7 Review of Process

7.1 This process will be implemented from August 2021. The SAR Panel will review effectiveness in November 2021, and on an annual basis thereafter.

8 Appendices

Appendix 1 – Need to Know process for Adult Social Care

Appendix 2 – Agency referral form to SAR Panel

Appendix 3 – SAR Quality Markers Guidance

9 Key Documents

- The Care Act 2014
- Care and Support Statutory Guidance
- Analysis of Safeguarding Adults Reviews: April 2017-March 2019
- ADASS London Multi Agency Adult Safeguarding Policies and Procedures
- https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan