Safeguarding Adult Review: “Robert” and “Stuart”

A Learning Briefing

What is a Safeguarding Adult Review?

A Safeguarding Adult Review (SAR) is a multi-agency review conducted by a Local Safeguarding Adults Board (LSAB). A SAR is about learning and improving practice: it is not about apportioning blame.

The Care Act 2014 states that a SAR must be commissioned by the LSAB if:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; or
- if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

In most circumstances, the LSAB sets up a SAR Panel, with membership drawn from partner agencies, and often invites an independent person to work with the Panel and write a report outlining the details of the matters under consideration and make recommendations, to the LSAB, for how future practice could be improved to prevent the same circumstances arising again. This model was followed in this case.

A Short Summary of the case

Robert had been subject to a series of serious assaults perpetrated by Stuart, (for which he was subsequently convicted and is now detained), while they were both resident in a specialist further education college which provided training and education for young adults with a learning disability. The college had not been made aware, during the admissions process nor subsequently, of Stuart’s previous behaviours which were the same or similar to those of which Robert became the victim, leaving him traumatised – traumas which will continue for some time to come.

The Learning Points

A number of learning points emerged, and the Coventry LSAB resolved to make this briefing available to other LSAB's (and to health, education and social care practitioners locally) as the lessons to be learned may apply in other parts of the country. It will be for each LSAB to judge.

Each agency who had provided services to the young men, both prior to and during their time at the college, produced an "Individual Management Review" (IMR) summarising the agency's involvement and actions.

The lessons to be learned from these tragic events – tragic, as things turned out, for both young men concerned – are reflected in the recommendations for future actions included by each of the relevant agencies in their IMR's. (Note: With the passage of time, many and possibly all the necessary actions may now have been completed. However, the Coventry LSAB will be auditing the action plans until they are assured that all actions have been fully implemented.)

The recommendations for action made by each of the agencies, with which the SAR Panel concurred, and which the Coventry LSAB subsequently approved, can be summarised as follows:

The College:

- To adopt a Model Admissions Policy from Coventry Local Authority
- To develop standard operating procedures for safeguarding during an admissions process
- To develop an escalation process should information not be shared at reference stage
- To deliver training for Designated Safeguarding Leads (DSL's), within the college, on in-house safeguarding
- To clarify DSL supervision requirements
- To ensure that there is a safer Admissions process, and guidance for best practice, in line with a Safer Recruitment protocol

Stuart's Local Authority:

- Information held in children's records to be accessible to adult workers: Transitions protocols to be reviewed and updated to include the process where referrals are received for a young person after s/he has attained the age of 18 to ensure that all information held in children's social care records and by other relevant agencies, is shared with adult social care colleagues, meeting any sharing of information protocol requirements.
- To ensure that the Transitions Process is fit for purpose: are single assessment, chronology, child in need reviews, pathway plans being shared with Adult Services as part of the referral process from children to adult services?
- To ensure that there is joined up working between education, social care and health as required by the SEND Code of Practice; preparation for adulthood work streams for education and employment, and health and social care to continue to confirm processes for joint working between education, health and social care.
- To review how risk information is accessible to all professionals across education, social care and health systems and appropriate processes agreed.

Robert's Local Authority:

- The local Learning Disability Team to review information sharing protocols between college placements that are not directly commissioned by Adult Social Care.

The Mental Health and Learning Disability Service:

- To review compliance with existing procedures relating to actions to be taken in circumstances in which a number of appointments are missed by the service user and/or the family.

Other Recommendations for Action

The SAR Panel made some additional recommendations to the LSAB. These were accepted:

- The Coventry LSAB should remind all partner agencies of the importance of, and need for, professional accountability and curiosity on the part of all staff, particularly in respect of questioning when there is a difference between an individual's behaviour and any pre-determined diagnosis (Stuart's diagnosis of a learning disability was subsequently found to be inaccurate)
- All staff should be reminded that it is vital that referrals are followed up, both by the receiving agency and the referring agency, and that full and accurate records are created and kept.

- That, in the context of multi-agency training, all professionals are encouraged to adopt a challenging role with each other to ensure that, where actions have been agreed by all, that the actions are taken.
- That the full SAR report is forwarded to OFSTED and CQC and to Stuart's home authority's LSAB and LSCB, for these agencies' consideration.