

# Hertfordshire

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## Safeguarding Adults Board

*Working together to prevent abuse*

The Care Act (2014) states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when 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.

The purpose of a SAR is defined very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

A mistake by a member of staff which causes a death may be negligent but it's not necessarily neglect as defined by the act.

The aim of a SAR is for lessons to be learned from the review(s) and for those lessons to be applied to future cases to prevent similar harm re-occurring.

There have been a total of 19 referrals since the Care Act came in: 2015-2016 = 8, 2016-2017 = 4, 2017-2018 = 7. Only four of these have become a SAR, two have been completed and a decision by the HSAB was made to not publish to protect the surviving family. One has recently been published [here](#) and there is one currently in progress.

### **Learning from National and Hertfordshire SARs**

It was recognized that a 'person centered approach' is best practice. The review highlighted individual agencies were providing excellent care in some cases. The cases where the failings were identified generally involved multiple departments or agencies contributing to the care. The individual agencies or departments were not working as well as they could with other agencies and not considering the case in the wider perspective outside of their department or agency.

The areas for improvement identified are:

- Awareness training
- Information sharing and communication
- Multi-agency joint risk assessments
- More multi-agency joint working with agreed ownership
- Co-ordination of complex multi-agency cases
- Record keeping with management oversight
- Understanding of processes within their agency and how to escalate concerns

- Transition cases – children to adult services
- Auditing

To truly ensure the safeguarding of adults from further abuse, processes and practices need to be improved as a result of the lessons learned and not simply *'this is what we have learned'*.

### **What has HSAB done?**

As a result of these learning's the HSAB is currently drafting Self neglect guidance for practitioners including a resource pack. Guidance on multi-disciplinary complex cases is also in development and both will be formally launched across the partnership later this year.

The Department of Health has commissioned SCIE and RiPFA to develop a SAR library. The aim is to maximise the value of individual SARs through two different kinds of resource. One will support the quality of individual SARs and the other will enable more widespread and effective use of the learning from SARs.

- Information about the new SAR library is available on the SCIE website – <https://www.scie.org.uk/safeguarding/adults/reviews/library/>
- Hampshire Safeguarding Adults Board SAR library - <http://www.hampshiresab.org.uk/learning-from-experience-database/serious-case-reviews/>