Leeds Safeguarding Adults Review Policy and Framework

Subject to LSAB approval 27th June 2025

1. Introduction

The undertaking of Safeguarding Adults Reviews is a specific legal duty placed upon all Safeguarding Adults Boards, by Section 44 of the Care Act 2014.

'The process for undertaking SARs [however] should be determined locally according to the specific individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action[i].'

Recognising the required flexibility of approach, this document outlines a framework for how Safeguarding Adults Reviews will be undertaken in Leeds. It forms part of the Board's ambition to 'learn from experience to improve how we work'. An approach that seeks to learn from people's experiences, improve practice and achieve the necessary changes that safeguard others in the future. Hence the undertaking of Safeguarding Adults Reviews sits within the wider responsibilities of the Board to 'coordinate and ensure the effectiveness of what each of its members do[ii]' and aligns with wider workstreams such as Learning & Development, Quality Assurance and the development of multi-agency policy, procedures and guidance.

2. What the law says:

Care Act 2014, Section 44: Safeguarding Adults Reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

Please note:

- **Section 1-3** defines the Board's legal duty to undertake a Safeguarding Adults Review often described as a Mandatory Review. Where these criteria are deemed to be met by the Safeguarding Adults Board a review must be undertaken.
- **Section 4** above defines the Board's powers to undertake a review – commonly referred to as a Discretionary Review. That is, the Board way choose to undertake a review in these circumstances if it deems it appropriate and necessary to achieve important learning.
- An explanation of terms is included within the **Glossary** at the end of this document.

3. Purpose of a review

The Care and Support Statutory Guidance states that safeguarding adults review are held to:

- "Promote effective learning and improvement action to prevent future deaths or serious harm occurring again"[iii].

The aim is to identify learning about how local professionals and agencies worked together to safeguard the individual, and for that learning to be used to prevent similar situations re-occurring in the future[iv]. The focus on how organisations worked together is significant, as a Safeguarding Adults Review does not replace any duty an organisation may have to undertake an internal review of practice. What it does is add value to the safeguarding system by addressing the working together issues between organisations that may not necessary be achieved by internal practice reviews alone.

4. Boundaries for a review

Individuals, their family members and professionals may all have their own hopes and expectations around what can be achieved by a review. These may not always be realistic or achievable and so it should always be made clear within the Terms of Reference what the intended purpose and expected outcomes are.

The focus on learning, improvement and change, means that there are clear boundaries around what a Safeguarding Adults Review can seek to achieve. The Care and Support Statutory Guidance states that: "It is not the purpose of a Safeguarding Adults Review to hold any individual or organisation to account, as there are other processes that exist for that purpose"[v]. And it is "not the purpose of a review to reinvestigate or apportion blame"[vi].

As such a review cannot:

- Seek to identify the cause of any death that has occurred, that is a matter for the Coroner's Court.
- Seek to identify who is culpable for the death of an adult at risk, as that is a matter for the Criminal Courts.
- Take enforcement actions against any organisation, as this will be the responsibilities of the regulators and commissioners
- Take actions against individuals, this will be the responsibility of professional bodies, organisations through their HR policies, and or the criminal justice system.
- Replace any individual organisations internal / statutory review procedures to investigate serious incidents, as may occur with an NHS Serious incident investigation
- Reassess any individual's health or care needs or assess their mental capacity to make decisions in retrospect.

5. Notification and decision-making process

5.1. Notification

Any individual can make a Safeguarding Adults Review notification. This includes individuals and their carers / relatives who feel a review should be undertaken in their circumstances. Professionals are encouraged to seek the views of their safeguarding leads / senior managers before making a notification. Similarly, practitioners whose organisations are represented on the Safeguarding Adults Board are encouraged to consult their board member before doing so. Details on how to make a notification is available on the Board website

5.3. Scoping decision

Any notification received will be reviewed by the Boards' Safeguarding Adults Review Sub-group. If, based upon the information provided, there is the potential for the legal criteria to be met, then all relevant agencies will be contacted to provide information about their organisation's involvement.

5.3. Sub-group recommendation

The SAR Sub-group will review all the responses provided by agencies and assess this against the legal criteria set out in Section 2. There are four possible outcomes

a. There is a legal duty to undertake a Safeguarding Adults Review
b. There is no legal duty, but there is merit in undertaking a discretionary review under the Board's powers
c. There is no legal duty, but there is individual agency learning to be achieved
d. There are no concerns requiring further Board action.

Appendix A sets out a decision tree to inform decision making.

Where the SAR sub-group requires further information in order understand the circumstances of the individual or the actions of an organisation, it will do this as needed before reaching a decision as to the recommendation. Similarly, it may request further information to inform the Terms of Reference for a review.

5.4. SAR Decision

The Safeguarding Adults Board is the statutory body responsible for undertaking a safeguarding adults review. As such any recommendations made by the SAR sub-group will be considered by the full Board, and a decision reached as the appropriate response. The outcomes will be as follows:

1. Undertake a Mandatory Safeguarding Adults Review (Section 7)
2. Undertake a Discretionary Safeguarding Adults Review (Section 7)
3. Seek individual agency assurances about learning (Section 6)
4. Confirm there is no further actions required by the Board.

6. Individual agency learning assurances

In the event that the Safeguarding Adults Review criteria is not met (or there are wider individual agency issues that are not within the remit of an agreed review), the Board will seek evidence of how organisations have taken forward learning. It may also ask for a joint response from agencies where there is a need for consistency or joined up practice.

Such a request is made under the Section 43(3) and Section 43 (4) provisions of the Act

- The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.
- An SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.

As such these actions extend beyond the Safeguarding Adults Review requirements, into the wider Board governance processes. This will usually take the form of an agreed template being sent out by the SAR sub-group who will review the responses and seek additional information as needed to gain that assurance. Once satisfied with the responses these will be reviewed by the Board. The Board could ask for a further assurance, either immediately or after a period of time to understand how plans have been embedded into practice.

7. Safeguarding Adults Reviews – Terms of Reference

Whether a Safeguarding Adults Review is undertaken as a Mandatory or Discretionary review, the same principles, process and requirements apply. In both cases, the Leeds Safeguarding Adults Board is committed to finding the best way in each case to achieve the necessary learning for citizens in Leeds. This means it has deliberately not committed itself to any particular review model and so it will respond to each Safeguarding Adults Review with the questions:

- What learning and change do we hope to achieve from this review?
- What approach is needed to achieve this?
- How can this be achieved in a timely way given the complexity of the presenting issues?

Appendix B sets out potential pathways to guide decision making, recognising that the starting point and therefore the required outcomes of review will be either:

- Exploratory to identify systemic inter-agency working concerns or
- A solution focused review based upon systemic learning and change, that supports and promotes best practice.

In both cases the review must have a clear focus, seek to address systemic practice issues, and focus on the achievement of best practice going forward. Establishing a clear focus for the review may involve separating out the aims of this multi-agency learning process from individual agency learning issues that can often be addressed in other ways. This could include the seeking of individual agency assurances as set out in Section 6, and so these may on occasion run concurrently with a Safeguarding Adults Review.

The Terms of Reference for any Safeguarding Adults Review will be developed by the SAR sub-group and be approved by the Board prior to its commencement. The SAR Quality Markers published on the SCIE website will be used as required, as a point of reference in developing the approach.

8. Principles relating to all reviews

Whichever format a Safeguarding Adults Review takes, the following principles apply in all cases:

8.1. The principle of inclusion:

A) Talk to me, hear my voice

Talk to me, hear my voice[vii] is the key message from people in Leeds. The phrase sums up how people wish to be involved and included. Whilst recognising that individuals or their families may understandably find it difficult or challenging to contribute to a Safeguarding Adults Review, they should be provided with the opportunity to take part if they wish to do so.

Each situation will be unique, and so careful consideration should be given to the best way of notifying and involving the individual and or family member within the review Terms of Reference.

In the event that the individual or family members raise concerns that are wider than the scope of the Terms of Reference, these views should be recognised and fed-back to SAR Sub-group or Panel that is managing the review. Consideration will then be given to amending the Terms of Reference, or whether there are alternative, more appropriate ways to address and respond to the particular issues raised.

B) Access to Independent Advocacy

Section 68, Care Act 2014 requires that each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. In circumstances where a person has died and relatives may also have a need for or benefit from an independent advocate this will be sought and provided wherever possible.

8.2. The Principle: A safe place to learn and develop practice

The Care & Support statutory guidance states:

- "It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them"[viii].
- "Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith[ix]"

8.3. The Principle of independence:

The Care & Support statutory guidance states:

- "Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed"[x]

The guidance notes that 'no one model [for safeguarding adults reviews] will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action'. In Leeds this independence may be achieved in a variety of ways depending on the circumstances and objectives of the review, for example:

- An independent author
- A review panel, inclusive of independent members
- Review and scrutiny by the Safeguarding Adults Review Sub-group
- Review and scrutiny of the Safeguarding Adults Board

8.4. The principle of openness and transparency

Safeguarding Adults Reviews require all organisations and participants to contribute with a spirit of openness about what has happened and how we can learn and improve future practice. The Care and Support Statutory Guidance states that:

- "there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice[xi]"

8.5. The principle of systemic learning

Safeguarding Adults Reviews have a unique role and purpose. The focus of a Safeguarding Adults Review should be on systemic learning and change. They should seek to look beyond the specific decisions, actions or inactions of individual practitioners, to identify and address the underlying factors that enable best practice to be achieved. These factors may be varied in nature, and might include cultural, process, procedural or system issues that impact upon how organisations work together. The objective of the review should always be sustainable change that seeks to improve safeguarding systems and services that help and protect others in similar situations in the future.

9. Issues of coordination

9.1. Coordination with Children Safeguarding Partnership and Safer Leeds Reviews

Safeguarding Children Partnership and Safer Leeds have statutory review processes which could overlap with a Safeguarding Adults Review, for example, where a person has just turned 18 years of age, or where the person has care and support needs and died as a result of domestic abuse:

- Child Safeguarding Practice Reviews
- Domestic Homicide Reviews

For these reasons, information shared for the purposes for a Safeguarding Adults Review may in turn be shared with Safeguarding Children Partnership or Safer Leeds if it will enable them to fulfil their own safeguarding functions. In the event that a review is undertaken by more than one of these Boards, there is a commitment to close collaboration and coordination as to how the learning can be sought and acted upon. The process for this will need to be agreed on a case-by-case basis depending on the nature of the issues.

9.2. Coordination with other Safeguarding Adults Boards

In circumstances where a person has moved residence or accessed services in more than one local authority area, a review may involve the safeguarding arrangements covered by one or more Safeguarding Adults Board. In these circumstances, the following principles apply:

- A Safeguarding Adults Review should be undertaken in the area where the person, 'died' or 'experienced serious abuse, neglect or self-neglect'.
- Close liaison and discussion should be held over the Terms of Reference for the review
- Relevant learning should be shared across Boards
- The individual circumstances and the SAR policies of the respective Board's will need to be taken into consideration as to how the review is managed and overseen.

9.3. Coordination with other review and investigative processes

A range of investigations or statutory review processes may inform the need or outcomes of Safeguarding Adults Review. This list other review or investigative processes only details the most common overlapping processes. It is not intended to be exhaustive:

a. Criminal Investigations –

   Advice will be sought from West Yorkshire Police prior to the commencement of a Safeguarding Adults Review so as to ensure no actions are taken that may prejudice an ongoing investigation.

b. Coronial investigations –

   Coordination with coronial investigations will need to be undertaken on a case-by-case basis taking into consideration national guidance: National SAB guidance on the interface between SARs and Coronial Processes.

c. Section 42 Safeguarding enquiries –

   A local authority safeguarding enquiry should not be delayed by consideration of the need for a Safeguarding Adults Review. Each has a distinct and separate remit, and one is not a prerequisite for the other. However, on a case-by-case basis, it may be appropriate for the Safeguarding Adults Review to await the outcome of the Section 42 enquiry, as the learning from this may inform the terms of reference of the SAR.

d. Serious Incidents Processes –

   Organisations may have their own internal or statutory review procedures to consider serious incidents. This SAR Policy and Framework is not intended to replace those in any way. Where the LSAB has decided to undertake a SAR, agencies are asked to share their learning and any reports to support that process.

e. Care Quality Commission -

   In accordance with Care & Support Statutory Guidance "All documentation the SAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC"[xii]. The CQC has a distinct role and function to that of the Safeguarding Adults Board and their respective process will usually run in parallel.

10. Timescales

The Board will always aim to complete a Safeguarding Adults Review within 6 months of agreeing the Terms of Reference. This will be achieved earlier wherever possible but the timescale achieved may depend upon the scale and complexity of the issues and the interface with other related process, such as a Criminal Investigation or Court Proceedings.

11. Supply of information

There is a duty upon organisations to provide the Board with information necessary to fulfil it statutory functions, including the undertaking of Safeguarding Adults Reviews. This is provided for under Section 45 of the Care Act 2014. In the event of any organisation receiving such a request, they may wish to refer to Section 6 of the LSAB Information Sharing Policy. This specifically concerns the provision of information for a Safeguarding Adults Review.

12. Learning themes and recommendations

Unless specifically stated within the Terms of Reference, any Focused Exploratory Review should identify learning themes and issues, that will be translated into actions by the SAR sub-group or a Task & Finish Group and agreed by the Board. A summary of learning and actions will be published on the Board website.

Action plans will be taken forward by the Board or individual member organisations depending on the circumstances. The completion of actions will need to be reported to the Board. Progress will be monitored by the Quality Assurance & Performance Sub-group and / or SAR sub-group, informed by the Learning & Development workstream.

In the event that the learning has regional or national implications this will be shared in accordance with the National Escalation Protocol for Issues from Safeguarding Adults Reviews from Safeguarding Adult Boards (2021).

13. Publication of learning

In the interests of transparency and dissemination of learning, the Board will publish an appropriately anonymised executive summary of the terms of reference, learning and actions taken forward. Depending on the circumstances, the review may sometimes be published in full but never in circumstances where this may impact on an individual's confidentiality, cause further distress to individuals or families affected, place any person at risk or compromise any other review/enquiry or criminal process.

14. Media interest

All media interest will be handled by the Leeds City Council Communications Team on behalf of the Board. Agencies will always be involved in discussion about the media strategy and where appropriate, the City Council's communication team will liaise with teams within those agencies.

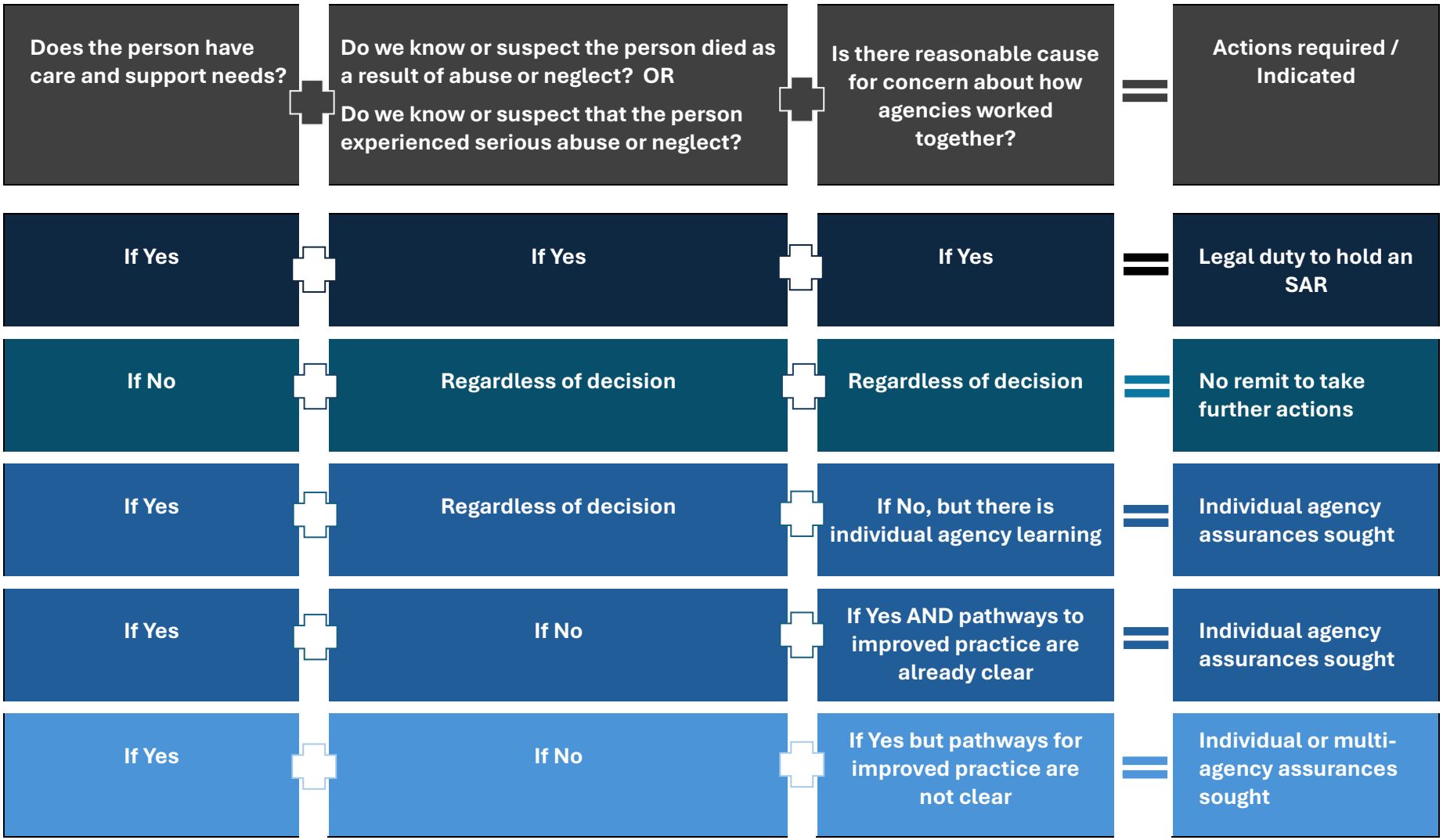
15. Complaints about Safeguarding Adult Review decisions

The Local Government and Social Care Ombudsman, (LGSCO) is able to investigate complaints about the decision-making processes of Safeguarding Adults Boards. The expectation of the LGSCO is that a complaint is raised in the first instance to responsible body, for this purpose this would be Leeds City Council (Adults Social Care). To do this, follow this link to the relevant Council website pages.

Additional Information

- For information about Data Retention Schedules relating to Safeguarding Adults Reviews, please refer to our Privacy Statement
- For information about the Board's exemption from Freedom of information Requests, see Chapter 5.2, LSAB Working Arrangements and our Privacy Statement

Appendix A: SAR Decision Outcomes



Appendix B: Safeguarding Adults Review Pathways

What is our starting point?	What are we aiming to achieve?	What would be our approach?	What this may look like	How is independence achieved?	How is the person/ family involved?
A) Issues already identified, pathway to improved practices is already clear	**What learning and change do we hope to achieve from this review?** Each review must have a clear focus, with clear aims and expected outcomes.	**Best practice review –** Solution focused - based upon the principles of what does good look like and how do we achieve this	Agency working together to identify new processes, protocols and procedures that respond to the working together concerns	Terms of Reference agreed by the Board Additional scrutiny from SAR subgroup or a designated panel Board evaluates outcomes report against TOR reference.	Person/family invite to share views/experiences and comment on work produced. Contacted by lead agencies
B) Review required to identify issues and pathways to improved practice	**What learning and change do we hope to achieve from this review?** Each review must have a clear focus, with clear aims and expected outcomes.	**Focused exploratory review:** External or locally based review possible*.	Author report identifying issues and areas of learning for the Board to consider. This may include: • Desk top review • Additional questions • Practitioner workshops • Learning themes	In addition to actions identified above: The report is produced by someone who the Board agrees can act independently of the issues raised.	Person/family invite to share views/experiences and comment on work produced. Contacted by lead agencies

* Focused exploratory review: External or local commission considerations:

1. Is their subject matter expertise required that is not available locally?
2. Are there resources available for this to be undertaken locally?
3. Is there a need for someone to be independent of the Leeds system or is there a benefit of them understanding Leeds processes?
4. Are there significant political, media or other sensitivities?
5. The number of agencies needing to be involved and the scale of the Terms of Reference
6. Whether a review needs to be undertaken across local authority boundaries? Does this influence our approach?

Glossary of Terms

These terms relate to the legal duty to undertake a Safeguarding Adults Review as set out in Section 44 of the Care Act 2014, and as reported above in Section 2 of this document.

A. 'Care and Support Needs'

Where a person has a physical or mental impairment or illness (including a mental health condition or substance misuse) they may need assistance to carry our aspects of their day to day living. This is referred to as a care and support need.

Care and support can be interpreted as the mixture of practical, financial, and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.

There only has to be an appearance of a need for care and support to trigger this criteria; it does not matter if those needs have not been met.

B. 'Serious abuse and neglect'

The definition of abuse and neglect includes self-neglect. The Care & Support Statutory Guidance, Section 14,163 offers the following guidance on the term: 'Serious':

"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".

C. 'Worked together'

This element will need to be considered in the context of i) specific circumstances and the ii) overall purpose of a Safeguarding Adults Review. In general terms:

i. Specific circumstances: These will need to relate to serious concerns about how organisations have worked together to prevent, identify, minimise or address a risk that have resulted in the person's death or led to serious abuse or neglect.

ii. Overall purpose of a review: It is not enough that there were concerns about the actions of an individual organisation, as these issues can often be addressed through other processes. The issues must relate to the overall purposes of a Safeguarding Adults Review and involve the actions or inactions of two or more organisations.

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[i] Care & Support Statutory Guidance, Section 14.170
[ii] Care Act 2014, Section 43 (3)
[iii] Care & Support Statutory Guidance, Section 14.164
[iv] Care & Support Statutory Guidance14,164
[v] Care & Support Statutory Guidance, Section 14,168
[vi] Care & Support Statutory Guidance, Section 14,164
[vii] LSAB, Talk to me, hear my voice – LSAB Website

[viii] Care & Support Statutory Guidance, Section 14,169
[ix] Care & Support Statutory Guidance, Section 14,167
[x] Care & Support Statutory Guidance, Section 14,167
[xi] Care & Support Statutory Guidance, Section 14.167
[xii] Care & Support Statutory Guidance, Section 14,177