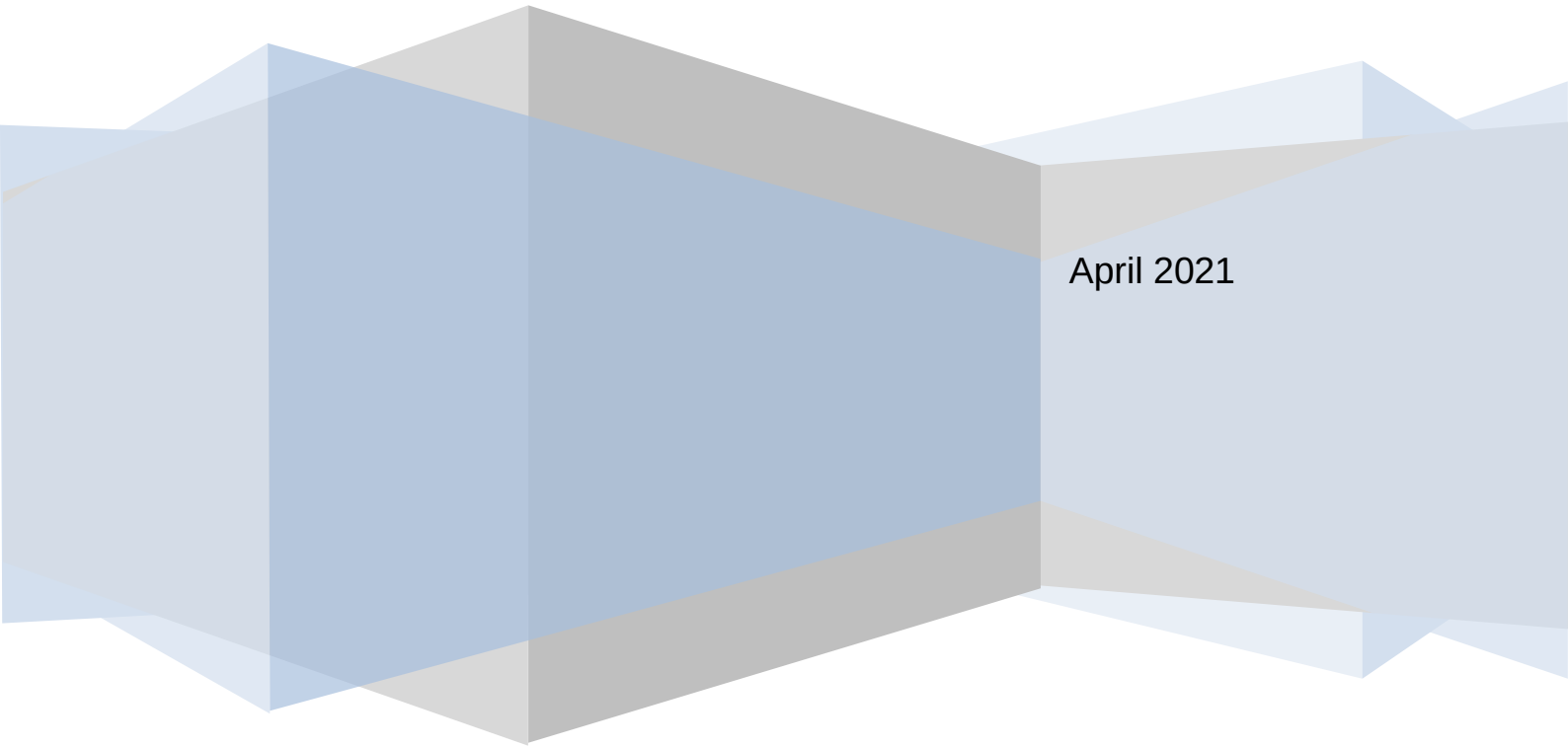
TAMESIDE ADULT SAFEGUARDING BOARD
SAFEGUARDING ADULT REVIEW (SAR) GUIDANCE



April 2021

Content

1. Introduction

This document sets out the arrangements by which a Safeguarding Adults Board (SAB) will conduct case reviews. It highlights the statutory duties, overall process for running a Safeguarding Adults Review (SAR), and how the SABs will commission such work.

The core process that the SAB) will utilise for all case reviews (both SARs and other reviews) is set out in this document.

The SAR process will be flexible depending on the nature and complexity of a case, and the same processes will apply for any recommendation received by a Community Safety Partnership (CSP) in relation to a Domestic Homicide Review (DHR).

It should also be noted that SABs are concerned with reviews of significant cases, some of which will become SARs and others may become reviews that will not meet the threshold but will be commissioned by the SAB when considered necessary.

The key aim of any review remains as set out in the following legislation:

- Care Act 2014.
- Domestic Violence, Crime and Victims Act 2004

A SAR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard adults.
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings.

2. Care Act criteria for conducting a Safeguarding Adult Review

The requirements in legislation to carry out a SAR is set out in section 44 Care Act 2014

44 (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 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 – ta) he 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 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.

Therefore, the Care Act requires SABS to arrange a SAR when: - An Adult in its area who is in need of care and support (whether or not the LA has been meeting any of those needs) dies as a result of abuse or neglect, or has experienced serious abuse or neglect, whether known or suspected

And

There is concern that partner agencies could have worked more effectively to protect the adult.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

The SAB will be primarily concerned with considering the most appropriate model of review. The review will promote:-

- Effective learning
- Improvement action to prevent future deaths or serious harm occurring again
- Opportunity to explore examples of good practice to identify lessons to apply to future practice

3. The six safeguarding principles defined within the Care Act Guidance that Safeguarding Adult reviews must reflect:

Empowerment – Personalisation and the presumption of person-led decisions and informed consent.

Prevention – It is better to take action before harm occurs.

Proportionality The least intrusive response appropriate to the risk presented

Protection – Support and representation for those in greatest need.

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability – Accountability and transparency in delivering safeguarding.

In the context of these principles SAB'S will conduct reviews ensuring:

- A culture of continuous learning and improvement, promoting the well-being and empowerment of adults, promoting good practice and focusing on opportunities to apply what works.

- A culture of transparency is created that identifies a flexible and proportionate environment for learning.

- A proportionate response that identifies timely action is taken to respond to the need for systematic or professional changes.

- Safeguarding Adult Reviews will be led by individuals who are independent of the case under review and of the organisation whose actions are being reviewed.

- Involvement of professionals in the review to be invited to contribute their perspective without fear of being blamed for actions they took in good faith.

- Families are invited to contribute to the reviews, understanding how they are going to be involved.

4. Types of Case Reviews

Consideration should be given to how reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

Safeguarding Adult Reviews (SAR) – Section 44 of The Care Act 2014 sets out the circumstances in which Safeguarding Adults Boards are required to undertake a Safeguarding Adults Review.

Domestic Homicide Reviews (DHR)– were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004.

Child Safeguarding Practice Reviews (SPRs) are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected . Additionally, Local Safeguarding Children Partnerships may decide to conduct an SPR if a child has been seriously harmed and in accordance with the guidance in Working Together 2018:

Independent Investigation Review (IIR)…when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past six months prior to the event.

5. The purpose of a SAR

The purpose of having a SAR is not to reinvestigate or to apportion blame, it is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults. It is the TASPB Learning and Accountability Principle and remit to ensure that the following are achieved:-

- agree what approach to take, proportionate to the circumstances
- define the Terms of Reference (TOR) and present to the SAB
- agree who will be invited to be representatives at the Review Panel and appoint a Chair for this Panel
- contact the adult, family or friends to ask how they want to be involved in the SAR
- agree who should be invited to contribute to the review, co-ordinate and document the review outcome.
- make arrangements to publish the Terms of Reference
- have oversight of documentation relating to the SAR, ensuring these are anonymised through redaction or consent is sought
- arrange to publish the SAR report as appropriate
- liaise with Organisations communications teams as appropriate and agreed by the SAB
- Check which other reviews are being undertaken

It should be noted that the Terms of Reference may change if significant new information is received. The SAR review panel will identify recommendations for change and present to the SAB for approval. The final TOR will be published in the SAR report.

Safeguarding Adult Reviews will:-

- Seek to determine what relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death
- Identify lessons learned and apply to future practice
- Be trusted and safe experiences for practitioners
- Encourage honesty and transparency
- Share information between organisations to obtain maximum benefit

SARs are not disciplinary proceedings, and should be conducted in a manner, which facilitates learning, and appropriate arrangements must be made to support staff.

SARs are not enquiries into why an adult has died (or been significantly injured), or who is culpable. These are matters for criminal courts and coroner's courts.

6. Notification of a serious safeguarding incident

The SAB is the only body that can undertake a SAR. Any professional can make a referral to request a SAR.

Making a referral - Any agency, professional or other individual must refer a case believed to conform to the Safeguarding Adult Review criteria. A referral must be made using the Safeguarding Adult Review Referral Form (See referral form Appendix 1). This must include a synopsis of the case that will be shared with SAB members and senior manager authorisation and will be submitted to the SAB.

Staff will usually find it helpful to discuss their concerns with their organisation's safeguarding lead prior to making a referral. Referrals are made via secure email.

Discussions regarding the appropriateness of referring a case are welcomed by the Safeguarding Adults Board Manager. Appendix 2 shows a flowchart of SAR referral process.

On receipt of the referral, the Safeguarding Adults Unit will ensure that the Chair of the Safeguarding Board is briefed on the circumstances.

7. Procedure for undertaking a SAR *(To ensure a consistent approach across GM this is the generic arrangements for all GM SAB's who will apply this approach to their local arrangements as appropriate)*

Once a referral for a SAR is received, the SAB will convene a meeting as defined in the local arrangements and the Chair of this meeting, supported by the Safeguarding Board Business Manager, will discuss with members of this meeting to consider whether the criteria are met.

Agencies can be asked for additional information by the SAB to inform a decision as to whether a review should take place. The SAB is responsible for deciding whether to undertake a review or not, based on the recommendations of provided.

The Safeguarding Board Business Manager on behalf of the SAB will inform the lead representative of the referring agency of the decision.

If the decision is to undertake a SAR, the Board will arrange to notify the individual, their family, friends or carers (where appropriate), of the outcome of the decision. This will provide an opportunity for the family/friends or carers (as appropriate) to contribute to the SAR.

When undertaking a SAR the records should be redacted or consent sought for the inclusion of personal data.

8. Recommending the Overall Approach to the SAR

Following the meeting to discuss the SAR Referral the following recommendations will be made to the SAB

- Which agencies should be asked to participate in the SAR
- Whether the agencies concerned are required to secure their files
- Which methodology should be used to facilitate learning in the case
- The Terms of Reference for the SAR
- The required output from the SAR (e.g. a report)
- The timescales for completion of the SAR. This should be within 6 months if possible.
- Recommendations relating to an independent facilitator/chair
- Recommendations relating to the commissioning of an independent author
- Recommendations relating to the approach to contact family to inform them of the decision to commence a SAR

The decision to hold a Safeguarding Adult Review

Agreement not to host a SAR as criteria is not met	**Additional Information is required prior to a decision being made if the SAR criteria is met**	**Agreement to host a SAR**
• SAB business support notifies the SAB Chair. • SAB Chair agrees with the decision and SAB business support update records and confirm decision via email with the SAB. • Referring SAB Lead informs organisation of outcome. • **Or** • SAB Chair disagrees with the decision and SAB business support notifies SAB TASPB Learning and Accountability Principle chair. • SAB TASPB Learning and Accountability Principle chair arranges an extraordinary meeting to respond to recommendations from the SAB Chair.	• SAB business support co-ordinate actions as agreed at the TASPB Learning and Accountability Principle. • SAB business support send diary invites to TASPB Learning and Accountability Principle.for next meeting to recommendation for a SAR. • Additional information required and distributed prior to meeting. • SAB TASPB Learning and Accountability Principle meeting confirm no further information is required and make their decision and recommendations.	• SAB Chair notified of recommendation. • Referring SAB Lead informs organisation of outcome. • SAR Review Framework implemented.

9. Links with other reviews

The SAB will consider how the review process with other relevant investigations such as DHR/SPR/IIR can dovetail at the beginning of the review and how duplication can be avoided. Any review will need to take account of a Coroners Inquiry and criminal investigations to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the Chair of the review to ensure contact is made to minimise avoidable duplication

Joint Borough Safeguarding Adult Reviews
Safeguarding Adult Reviews held jointly with other Boroughs will adopt the learning and improvement framework of the Borough hosting the review. Learning for the SAB from these reviews will be facilitated by the SAB TASPB Learning and Accountability Principle

Out of Borough issues in relation to responsibility for a SAR

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 these needs (Care Act:2014))

If a Safeguarding Adults Review is being considered the SAB of the host authority will be responsible for liaising with all partner agencies involved. The SAB in those areas would be contacted to be advised of the SAR but not expected to collate the information on behalf of the hosting SAB.

The host SAB will liaise with relevant Board Managers and Independent Chairs to obtain supporting information.

As stated in the Care Act, section 44, Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the relevant Board Managers, with ultimate decision making and discussion being resolved by the Independent Chair of the Safeguarding Adult Board. Independent Chairs will agree on the mechanisms for presenting SARs that have shared learning.

Concurrent Police Investigations or judicial proceedings
The SAR will need to take account of a Coroners Inquiry and criminal investigations to ensure that relevant information can be shared without incurring significant delay in the review process. In the first instance the SAB TASPB Learning and Accountability Principle will consider these actions and it will be the responsibility of the Chair of the review to ensure contact is made to minimise avoidable duplication

Coroners
Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of an adult who was at risk of abuse or neglect or who may have suffered such abuse or neglect. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations;
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home);
- The Coroner or his or her officers identify deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions.
- In the above situations, the SAB should consider instigating a SAR

Local Learning Review

Consideration may be given for a Local learning review and the SAB Lead for the relevant organisation would update the Board as appropriate.
A SAR should also take account of any other review process e.g. Learning Disabilities Mortality Review and should inform the development of the Terms of Reference as above.

10. Timescales

All requests to hold a SAR will be dealt with in accordance with the decision making process set out in paragraph 8 above. The meeting to discuss the SAR Referral will be established within 15 working days of the request being received.

. The conclusions of the meeting and the SAB's recommendations should be provided in writing within 5 working days of the meeting to the Independent Chair of the Safeguarding Adults Board, who will make the decision on whether there should be a SAR within 5 working days.

Once the decision to undertake a SAR has been made, it is good practice for it to be completed within six months.

11. Appointment and Role of the SAR Panel Chair

Appointment of the Chair should be in line with local guidance and procurement arrangements as appropriate. Any formal procurement process and contract with the independent reviewer should make reference to the SAR quality markers. See Appendix 5

The SAR Panel Chair should be an experienced individual who is not directly associated with the case.

The SAR Chair Panel should confirm if there is a conflict of interest as appropriate.

The SAR Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final report based on the Individual Management Reviews and any other evidence the TASPB Learning and Accountability Principle decides is relevant.

Consideration should be given to the skills and expertise required to effectively Chair a SAR.

They should have the appropriate core skills including:

- Strong leadership and ability to motivate others
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- Collaborative problem solving experience and knowledge of participative approaches
- Ability to find and evaluate best practice
- Good analytic skills and ability to manage quantitative and qualitative data
- Knowledge of safeguarding adults
- Ability to write for a wide audience and have an understanding of the complexity of the health and social care system
- The Reviewer will be wholly responsible for their own personal taxation responsibilities.
- The Reviewer will give assurance that they understand the requirements of the General Data Protection Regulations and how it impacts on the retention of any information stored by them connected to the SAR.

The Terms of Reference may, however, need to be revisited as the review progresses and as new information is identified. If appropriate, the SAR Panel will make a recommendation to the SAB to the terms of reference TASPB Independent Chair will approve the amendments and the TOR will be revised.

The SAR Review Panel Chair will establish an agreed timetable of review panel meetings in accordance with the required timescales of the review and set specific parameters, including timescales, for the completion of IMRs.

The Review Panel Chair will regularly update the Independent Chair of the Safeguarding Adults Boards on progress with the SAR.

The Review Panel Chair will maintain contact with the Safeguarding Board Business Manager, of all parallel review or investigation processes, and to ensure that any coordination and joint commissioning arrangements are effective.

The Review Panel Chair should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

Where there is an on-going criminal investigation the Review Panel Chair will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

12. Membership of the SAR Panel

- Representatives will be agreed following agreement of the TOR and the initial SAR Panel meeting Representatives will be appointed from agencies involved in the case
- Representatives will not be directly involved in the case but will have knowledge of the service and practice within it.
- Representatives will be consistent, deputies permitted in exceptional circumstances

13. Frequency of Meetings of the Review Panel

Meetings should be a minimum of one month between each meeting and dates agreed as appropriate at the first meeting of the Review Panel

14. Quorate

Meetings of the SAB to consider a decision whether to hold a SAR requires a minimum of one representative from each of the Statutory Partners as defined in the Care Act:-

- Local Authority
- Clinical Commissioning Group
- Greater Manchester Police
- All appointed representatives are required, deputies permitted in exceptional circumstances

15. Chronologies

Chronologies are used to inform the safeguarding adult review**.** Chronologies should be undertaken by managers who have not had operational responsibility for the case but understand the service. The Chronologies should reflect current practice and timelines will be case dependent.

16. Methodology

SARs can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies, led by an independent overview report author. With this method, individual agencies are asked to review the practice within their organisation through Individual Management Reviews (IMRs) and Chronologies, which then form part of an :Overview Report.

Other methods considered for a review:

- Action Learning Approach
- Peer Review Approach
- Thematic Reviews
- Single Agency Review
- Practitioners Learning Events Meeting

Safeguarding Boards will endorse the approach best suited to the circumstances of each individual case, and the initial meeting to discuss the SAR referral and confirm the decision to progress with a SAR will decide on the most appropriate method.

17. Involvement of Family Members, Friends, and other Support Networks

Care Act 2014 statutory guidance indicates that adults, their families and/or representatives should be invited and supported to contribute to SARs. This will enable an inclusive approach and ensure that their wishes, feelings and needs are fully considered. The Safeguarding Board Manager will arrange for contact to be made with the adult, their family and/or representative to inform them that a SAR referral has been received and accepted for scope and to establish:

(a) How they would like to be involved, e.g. telephone conversation, written communication, face to face conversation
(b) Any support or adjustments they would need to facilitate their involvement
(c) Their initial views, wishes, concerns and any answers/outcomes they would like to achieve from the SAR

The Local Safeguarding Adults Board has developed a leaflet that supports members of the public to understand the purpose of a SAR process which may be shared with family members and friends – see Appendix 4 & 6

Local Authorities must arrange an independent advocate for adults who are subject to a SAR if the following two conditions are met:

that if an independent advocate were not provided the person would have substantial difficulty in being fully involved in the process

and

there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer

It is for the local authority to form a judgement on a case by case basis about whether the adult has 'substantial difficulty' in being involved in the SAR process.

The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations as required for the SAR, to help them to understand and take part in the review and to express their views wishes or feelings.

Some SAB Chairs meet families as part of the decision making in respect of a SAR or consult the family on the terms of reference and scope of the SAR. This may take place prior to deciding to hold a SAR in some cases or with the SAR Reviewer/ Author.

It will also be sensible to provide office based contact numbers for families throughout their experience of the SAR process and it is recommended that the Board generic email address and telephone is used by Independent SAB Chairs and Reviewers and that they are advised not to disclose any personal contact information through social media or publicly available sources.

Family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the review panel have opportunities to listen to family experiences and perspectives and that these contribute meaningfully to the final report.

Family members can include:

- Siblings
- Parents
- Carers
- Grandparents
- Other significant family members identified from the Family Association Network/Genogram.

As a minimum, family members should:

- Be notified of the review process, what that means for them and how they can access support – including impact of media coverage.

- Agree the level and frequency of contact with family members to ensure they are kept informed.

- Supported to contribute to the review process – either in writing, by meeting with the review panel, sharing views via a third party or by other means identified by the review panel.

- Included in feedback about the learning identified by the Review Panel.

- Informed and prepared for the publication of the report in a timely manner – again including the likelihood of media interest.

- Provided with a read only copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version – A ‘hard’ copy of the report should not be provided until the report is in the public domain.

- Receive accessible information about the SAR process and other mechanisms for redress if they have concerns/complaints.

18. The Final Overview Report

The SAR overview report brings together the learning, themes identified from the review and will analyse and comment on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the adult.

The SAR overview report should firstly be presented to the SAR Review Panel. This provides an opportunity for the Chair of the review panel along with the SAR Review Panel to quality assure the document, reference the identified learning and to ensure an opportunity for the findings to be challenged where necessary.

Once agreed the Chair of the review panel should present the report to the Safeguarding Board, supported by the SAR Review Panel

It will be the responsibility of the Safeguarding Board and its Independent Chair to identify and agree how practice challenges or recommendations from the SAR Report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

The SAR report will:-

- be concise
- anonymised
- provide a sound analysis of what happened
- provide an analysis of why and what actions need to be taken to prevent an occurrence happening in the future
- be written in plain English
- contain findings of practical value to organisations and professionals

19. Action plans

A clear SAR action plan should be developed by the Safeguarding Board with a focus on improving outcomes for adults at risk of abuse or neglect... The following should be included in the Action Plan as standard:

- A timeline for publication of the report should be developed and where possible a date identified.

- Action is taken by the Safeguarding Board to share the findings of the report with the practitioners who contributed to the Practitioners Learning Event and with family members.

- Safeguarding Board will identify how it will share the lessons learned, and practice impact with the wilder workforce in the local area.*(e.g. 7 minute briefings and newsletters)*

- Once the SAR report and action plan have been agreed, the report will be endorsed and signed off by the Safeguarding Board and copies to be available on the local council's website.

- The action plan will be regularly reviewed and its impact evaluated using existing local Safeguarding Board processes.

- Individual organisations should continue with action plans which are relevant to their organisation

20. SAR will inform SABs Annual Report

The findings from any SAR should be reported in the SAB Annual Report and what actions it has taken or intends to take in relation to those findings. Where the Safeguarding Board decides not to implement an action, then the Annual report must state the reason for that decision.

21. Communication Strategy

Appendix 3 outlines the communication strategy.

The Chair of the SAR Review Panel, in consultation with the Independent Chair, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

Since the Local Authority is, the lead agency, media and communication issues will usually be co-ordinated by the council's communications team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.

All SAR reports will be considered for publication on the website of the relevant Safeguarding Boards. In the case of publication, the Independent Chair of the Safeguarding Boards will release a statement where appropriate.

Coroners may want to be in receipt of the final report. The independent Chair of the Safeguarding Board will liaise with the Coroner's office as appropriate.

22. Escalation & Complaints procedure

If the subject in question is opposed to a SAR being commissioned then further works is required to ensure that the person understands the statutory responsibility of the Board and that if the criteria are met there is a legal duty for a SAR to be commissioned. Further involvement would then need to be considered to ensure the individual feels inclusive to the process i.e. fully represented with family friends or advocates to ensure the individual is fully inclusive and satisfied with the outcome.

Where there is challenge to matters relating to the SAR Protocol or process, concerns should be communicated to the SAB Manager who will raise these for discussion within the most appropriate forum e.g. Review Panel, Executive Safeguarding Partnerships etc.

The SAB Independent Chair will have the final judgement where there are concerns or challenge in relation to a recommendation from the SAR Review Panel...

Where a complaint is received about a Board process, for example a Safeguarding Adult Review, this will initially be responded to by the Board Manager in consultation with the Safeguarding Boards Chair, with a written response within 28 days of receipt.

If the complainant is unsatisfied with the response, they should contact the Board Manager who will arrange for their complaint to be considered by the Independent Chair.

The Independent Chair will provide a further written response within 28 days of the complainant contacting the Board Manager. All written complaint responses will include details of how to contact the Local Government Ombudsman.

The SAB Business Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation.

23. Presentation of Report to Safeguarding Adults Board

The Review Panel Chair will present the Draft SAR Report to SAB. The report will be made available prior to SAB members attending the Board Meeting. This is to allow organisations to consider the report and their contribution to the Action Plan.

SAB may be required to call an Extraordinary Meeting if timescales agreed in the TOR prescribe this.

SAB may identify additional learning to inform strategic direction for individual organisations or collectively as a Board they may champion specific learning.

Primarily the SAB will be concerned with:-

- what needs to be learnt,
- where services and practice require improvement,
- and how any programme of action will lead to sustainable improvements.

The Report and Action Plan will be signed off by the Board and monitored adopting local arrangements. Quarterly updates will be presented to Board.

Appendix 1

CONFIDENTIAL WHEN COMPLETED

SAFEGUARDING ADULT REVIEW REFERRAL FORM

Cases should be referred initially to the SAB lead for your organisation for consideration if an adult at risk of abuse or neglect has died or been seriously harmed, and abuse and neglect are believed to have been a factor.

This form can be completed by any professional who has become aware of a case where the above criterion is met. All information provided should adhere to information sharing protocols and have due regard to the Mental Capacity Act and Best Interest Decision protocols.

Please note there is a statutory (Care Act 2014 Section 45) for agencies to share relevant personal data with the Safeguarding Adults Board.

To make a referral please complete this form only

- Provide as much information as is known at the time you complete referral in order to make a notification to the SAB
- If information is not available at this time do not delay in sending in notification

REFERRAL DETAILS			
Date of Notification			
Name of Referrer			
Role of Referrer			
Agency			
Address			
Tele			
Email			
Name of agency safeguarding lead			
ADULT DETAIL (SUBJECT OF REFERRAL)			
First Name(s)		Surname	
Known Alias(is)			
Date of Birth			
Home Address			
Date of Death (if applicable)		Date of Incident (if applicable)	
Gender		Disability	
Ethnicity		Faith / Religion	
GP Name		GP Practice Contact Details	

LEGAL STATUS OF ADULT (tick as appropriate)			
Detained under Mental Health Act		Subject to Section 117 (Mental Health Act)	
Lasting / Enduring Power of Attorney Registered for Health/and, or Finances?		Subject to Deprivation of Liberty Safeguards (DoLs) & Liberty Protection Safeguards (LPS)	
Legal Status Unknown		Other (please add in)	

HAS THE PERSON OR THEIR REPRESENTATIVE BEEN CONSULTED ABOUT THE REFERRAL? YES/NO
(Further Comments)

CRITERIA FOR SAFEGUARDING ADULT REVIEW

(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 GIVE AS MUCH INFORMATION AS POSSIBLE TO DEMONSTRATE REASON FOR REFERRAL AND THAT CRITERIA IS MET.

PLEASE NOTE THAT PURPOSE OF REFERRAL IS TO DETERMINE IF CASE MEETS CRITERIA FOR A SAR OR ANOTHER TYPE OF REVIEW OR AUDIT AT THIS STAGE

RATIONALE FOR REFERRAL *(please detail the reason for referral when considering the above criteria)*			
Date(s) of Incident		Date of Death	
Location of Incident			
Outline events and circumstances which triggered referral: *This is to help establish if the case meets the criteria for conducting a Safeguarding Adult Review – you do not have to provide detailed analysis at this stage*			

REASON FOR ANY DELAY IN REFERRAL

ACTIONS ALREADY TAKEN *(provide summary of outcome of Section 42 and case conference if appropriate)*

IS A CORONER KNOWN IN THIS CASE *(Details of information to be provided below)*

AGENCIES KNOWN TO BE INVOLVED WITH THE ADULT *(please include names and contact details)*			
Name	**Agency**	**Contact details**	**Are they still involved?**

Any comments and Sign off by your agency Safeguarding Lead

This is to confirm that the referral has been quality assured regarding information provided

Name _____ **Date**

Referrer Name _____ **Date**

Sign off by Safeguarding Lead

Name _____ **Date**

THIS REFERRAL IF NOW COMPLETE.

PLEASE EMAIL THE COMPLETED FORM TO *(SAB email address)*

For Completion by SAB Business Unit	
Initials of Adult	
Date referral received by SAB	
Date referral received by Chair of SAB TASPB Learning and Accountability Principle	
Date of call for information to agencies	
Deadline for agencies to submit information	
Date of initial screening meeting	
Date recommendations submitted to SAB Chair	
Date of decision of SAB Chair	

SAFEGUARDING ADULT REVIEW TIMEFRAME

DAY		DEADLINE
	Referral Received Assurance Lead: • checks referral detailed, appropriate, signed off by line manager and QA'd by agency's Safeguarding Lead • Seeks advise from Professional Advisor • Confirms decision to scope with sub-group Chair – before starting clock on day 1	
		Business Unit circulates to key agencies to screen providing: • Chronology re involvement • Analysis of significant events • Implications for practice & outcomes for individual Agencies have 10 working days to respond
		Business Unit collates all agency returns into one document
		Collated document and referral paperwork sent to Screening Panel members
		Screening Panel meet to screen referral within 15 days
		Business Support writes up minutes of Screening Panel
		Assurance Lead completes paperwork for screening with recommendation
		Chair of Screening Panel approves paperwork
		Passed to Independent Chair for sign off

APPENDIX 2

SAR Process Flow Chart

Appendix 3

Communication strategy re: SAR publication
All responsibilities for the Safeguarding Boards business manager unless otherwise stated

On completion of SAR
In Final Panel meeting have a discussion with partners about Communication issues and agree what information needs to be communicated and to who.

In preparation for inquest

- Head of Safeguarding and/or Safeguarding Board Business manager will liaise with Communication re statements in relation to inquest - prepare statement in advance. Director of Adult Social Care will make a statement on behalf of the Council as and when required.
- Head of Safeguarding and/or Safeguarding Board Business manager to write Communication statement in co-operation with Communication and provide this to Panel members.
- Communication to provide statement from Press on request.

In preparation for publication of SAR

- Agree a date for publication.
- Ensure Panel have had final version of Overview report
- Send finalised report to SAR repository and
- Agree publication style - pro-active press statements or publish on website.
- Liaise with Council Communication about potential for press interest re publication.
- Inform family by letter.
- Inform independent reviewer.
- Inform lead member and Chief Exec. Consider if an elected members brief is required
- Notify Website team of intention to publish on the Safeguarding Board website.
- Liaise with Panel members so that their Communication departments can be alerted - panel members to provide communication lead from their respective organisation.
- Final version of reports to be circulated to Communication reps as required
- Partners need to have their own statements ready and liaison should take place with Local Council Communication about prepared statements.
- If partners have media, queries they must liaise with Local Council Communication link person before making a response so that the level of exposure and risk can be assessed.
- Inform Safeguarding Board partners of intention to publish any reports on either of the Local Council or Safeguarding Board websites, and what information will be provided alongside with the report. Usually this will be 7-minute briefing but it may include a summary of the changes that have taken place because of the SAR and an explanation about delays in publication.
- Report onto website - circulate link to partners

Appendix 4

SAMPLE TEMPLATE LETTER TO FAMILY MEMBERS, FRIENDS AND CARE GIVERS

DATE: XXXXX

Dear XXXXXXX,

Firstly may I offer my condolences on the sad death of XXXXXXX. I am writing to let you know that XXXXXX Safeguarding Adult Board has decided to undertake a Safeguarding adults review (SAR).

The Safeguarding Adult Board (SAB) has a duty to conduct a SAR in certain circumstances when an adult at risk dies or is seriously injured. The purpose of a SAR is to consider whether there are lessons to be learnt about the ways that agencies, and individual professionals worked together.

XXXXXXX has been appointed as the Independent Reviewer; he/she has no connection with any of the agencies involved other than for the purpose of undertaking reviews.

XXXXXX has organised the 1st panel meeting which will take place on XXXXX, the purpose of the meeting is to scope the review and set a future date for a practitioners learning event.

I appreciate that this is a very difficult time for you. As part of this process we would like to have your involvement, and XXXXX will make contact with you in due course.

In the meantime, the review will continue, and I would be grateful if you could have a look at the enclosed leaflet as it gives more detail about reviews of this nature and how information will be gathered and shared to learn and improve services where necessary.

If you have any questions or concerns about any aspect of the review process please contact XXXXXX

Yours sincerely,

TASPB Independent Chair
Email: XXXXX
Tel No: XXXX

Appendix 5

COMMISSIONING LETTER TO INDEPENDENT AUTHOR

Dear XXXXXX,

Our Ref: XXXXXXXX

Following our discussions earlier this week, I would like to formally commission your services on behalf of the Local Safeguarding Adult's Board as Independent Chair and Report Writer in respect of the Safeguarding Adult Review we discussed.

The commissioning arrangements are as follows:

The LSAB Business Unit will provide business support which includes dealing with all enquiries, arranging for partner agencies to complete relevant documentation, compiling agendas, taking minutes and arranging meetings as required. Your named LSAB contact will be XXXXXXX. Contact details as follows:

E-MAIL:XXXXXXXXX
TEL: XXXXXXXXXX

Your LSAB contact for this review can advise on presentation and composition of the Overview Report if required and in consultations with members of the review panel and also in accordance with the agreed LSAB guidance for the review process.

As Independent Review Chair you will be expected to:

- Attend and Chair all Case Review Panel Meetings.
- Develop Terms of Reference specific to the particular case in consultation with the Review Panel.
- Work with and report to the Review Panel for the case, who will fulfil the role of project board, at agreed intervals,
- Where appropriate, liaise and consult with the family of the adult, Chairs of parallel reviews, Senior Investigating Officers and others who may have significant information to share.
- Work with the Review Panel to appropriately challenge and scrutinise individual agency practice, identify lessons to be learned and put forward recommendations for the LSAB.
- Work with the Review Panel to ensure that any issues of information sharing and confidentiality are discussed and agreed prior to any disclosures being made.
- Write an overview report, identifying specific, measurable, achievable realistic and time bound outcomes.
- Work with the Review Panel to ensure that the report accurately and comprehensively reflects the issues and themes pertinent to the particular case

- Present the completed report, as agreed, to the LSAB
- Liaise with agencies involved in parallel process as appropriate e.g. Independent Police Complaints Commission, Domestic Homicide Reviews, Child Safeguarding Practice Reviews, Coroner's Inquests

As report writer you will be expected to:

- Liaise with the Independent Chair or SAR Sub-Group Chair as appropriate
- Prepare draft and final report
- Make any amendments as identified by the review panel to said reports following quality assurance process.
- The agreed fee will be £XXX per day, which includes travel within the commissioner's area and in normal working hours. Please itemise your hours when you submit your invoice. You will receive payment 40 days after the submission of your invoice.
- The agreed timeframe for the review expects completion by XXXXX; should the review be subject to delays, you must inform the Safeguarding Board Manager that the review timescales may not be met at the earliest opportunity and agree a new completion date.
- Should there be a disagreement about the quality and content of the work, a meeting will be convened to discuss a plan for resolving the issue. The Independent Chair of the LSAB and LSAB members retain the right to accept or reject the final report.
- Information associated with this Safeguarding Adult Review will remain the property of LSAB

Please sign and date the declaration shown at the end of this letter indicating that you will comply with all of the commissioning arrangements contained in this letter and return this to XXXXX.

Please contact me if you need clarification on anything contained in this letter.

Yours sincerely

XXXXXXXX
LSAB Business Manager

Declaration:		
I, XXXXXX, will comply with all the commissioning arrangements referred to in this letter		
Signature:		(Independent Reviewer)
Date:		

Signature:		(LSAB Board Manager)
Date:		

Appendix 6

LEAFLET FOR FAMILY MEMBERS, FRIENDS AND CARE GIVERS

SAFEGUARDING ADULT REVIEW (SAR)

WHAT ARE SAFEGUARDING ADULT REVIEWS?

Safeguarding Adult Reviews are one way to improve how well services respond when there have been events that resulted in a death or serious injury and with the aim to prevent what happened to your family member happening to others. They will try to ensure that public bodies like social services, councils, police and other community based organisations understand what happened that led to the death of your family member and identify where responses to the situation could be improved. From this, the public bodies hope to learn all the right lessons including those which impact how they work together. These reviews will not seek to lay blame but to consider what happened and what could have been done differently. They will also recommend actions to improve services in the future.

Safeguarding Adult Reviews are part of the Care Act 2014 and became law from 1st April 2015.

WHO WILL UNDERTAKE THE REVIEW?

A review team will be formed of members of local statutory and voluntary bodies but it will not include any officials who have been directly involved in the case. The review team will look at how the entire community's response could be improved to help better support victims.

YOUR INVOLVEMENT IN THIS REVIEW

We think friends, family members and other people who knew the victim and perpetrator are the best people to help officials understand what happened. Victims often tell their family about the abuse they suffered and, sometimes, about their experiences in asking for help. It follows that family members can help public bodies to identify what lessons should be drawn from this tragedy, so your voices need to be heard.

TAKING PART IN THE REVIEW

If you do decide to take part in the review, you will be asked by the review team to share your understanding of what happened and why. This might include your thoughts, memories and point of view on any aspect of this tragedy. The review team are trying to ensure that the circumstances around the death of your family member are understood as far as possible and that learning is used to prevent further deaths in the future. As part of this, you might know about attempts your family member made to seek help from public bodies, community organisations and others because sometimes not all of these contacts are known to review team. You might also want to recommend other persons you think should be invited to submit a view.

You can give your thoughts and views in all or some of the following different ways:

- In writing or via a recording
- Via a telephone conversation
- Face to face meeting with some of the reviewers – this meeting would not take place in a court and you would be asked to share your thoughts under oath. The review would ask questions to assist the discussion and the whole process would last no longer than a few hours or as long as you feel able to participate.

WHAT HAPPENS TO THE INFORMATION YOU SHARE?

The information you share will help the review team to build a comprehensive picture of what happened before the death or serious injury and in turn will help the team formulate their recommendations for change. These recommendations will then be put into an action plan. Your input will be confidential and you will not be named in the review report.

Your contribution will be valuable and may help change the way the community, including public bodies, respond to serious situations in the future.

HOW LONG WILL THE REVIEW PROCESS TAKE?

The review should be completed within six months but could be for a longer period, for example because of potential prejudice to related court proceedings. Every effort should be made while the review is in progress to capture points from the case about improvements needed and to take corrective action.

WHAT DOES THE REVIEW PRODUCE?

- A detailed report and summary of that report which will be available on a public website.
- An action plan to ensure any recommendations made in the report is taken forward appropriately.

NEXT STEPS

The decision to take part in this review is entirely yours and if you do not wish to take part your decision will be respected. We may need to contact you again to let you know when the review has been completed. If you would like to take part or have any further questions about the review process, please contact the person who has signed the letter attached to this leaflet. They will either answer your questions or direct you to someone who can.

COMPLAINT/CONCERN

If you have a complaint, you must contact the SAB Manager in writing, who will then arrange for your complaint to be considered by the SAB Independent Chair.

A response would be received within 28 days of receipt of your complaint. If you are unsatisfied with the outcome of your complaint, you should contact the SAB Manager who will arrange for the SAB Independent Chair to reconsider your points.

The Independent Chair will provide a further written response within 28 days. All written complaint responses will include details of how to contact the Local Government Ombudsman.

All written complaint responses will include details of how to contact the Local Government Ombudsman.