North of Tyne
Safeguarding Adults Review
Policy and Procedure
April 2018

Contents

Glossary of key acronyms

IMR	Individual Management Review
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review

1. Introduction

Newcastle, North Tyneside and Northumberland Safeguarding Adults Boards (hereon in referred to as “the SABs” throughout this document) believe that preventative services do more to reduce abuse and neglect of adults at risk than reactive services; however there are times when we need to learn lessons as a result of incidents that have already occurred.

A Safeguarding Adults Review (SAR) is a process that enables all partner agencies to identify any lessons that can be learned from particularly complex or difficult safeguarding adult cases and implement changes to improve services in the light of these lessons.

The aim must be to learn from past experience, improve future practice and multi-agency working. It is not the role of Safeguarding Adult Reviews to apportion blame - that is for the courts or other arenas.

The SAB’s will promote a culture that:

- Values professional expertise;
- Shares responsibility;
- Develops professional expertise and supports effective practice;
- Strengthens accountabilities and creates a learning system.

Case reviews have developed as a significant learning mechanism in child and adult safeguarding. There is a clear expectation in the Care Act 2014 that SABs should be commissioning and learning from SARs.

2. Purpose of a Safeguarding Adults Review

The purpose of having a SAR is not to reinvestigate or to apportion blame, undertake HR duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local inter-agency practice;
- To improve practice by acting on learning (developing best practice);
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There should be a strong focus on understanding the underlying issues that informed agency/professionals' actions and what, if anything prevented them from being able to properly help and protect adults at risk of harm from abuse.

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents; e.g. an Untoward Incident. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

Where there are possible grounds for both a SAR and another multi-agency statutory review process (e.g. Domestic Homicide Review, Children's Serious Case Review) then a decision should be made at the outset by the decision-makers as to which process is to lead, how information will be contributed, and how any learning will be disseminated through the relevant partnerships. When this circumstance arises, good governance arrangements will need to be arranged at the outset[1]. The same principles should apply if the case has cross-boundary features. It may be necessary to coordinate a joint meeting between the relevant committees.

[1] NSPCC Serious Case Review Quality Markers, "Parallel Processes"

3. Criteria for conducting a Safeguarding Adults Review

Section 44 of the Care Act 2014 places a **duty** on local SABs to arrange SARs.

The Care Act 2014 states that:

> 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.
> 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.
> 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).

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.

SARs can also be used to explore examples of good practice where it is likely that lessons can be applied to future cases.

There may be circumstances where the above criteria have not been fully met but it is felt that a review of the case would be beneficial. This is a decision for the Safeguarding Adults Review Committee – Newcastle or North Tyneside/Northumberland. Hereafter these will be referred to as “the SAR Committee”.

The following checklist should be referred to where there is a decision to undertake a Safeguarding Adults Review:

It must be satisfied at the start that:
Consideration has been given as to whether a conclusive finding of wrongdoing is likely to be involved or whether that is the role of another court or tribunal, which is responsible for making such findings.
Those appointed to conduct the review/investigation have an open mind and are independent of those agencies involved.
At least one of the participants in the review process is legally qualified.
The people involved in the review process have been advised the review will be based on facts. Evidence should be tested and should be open to challenge by those persons affected by them and opinions are of little evidential value on technical matters which lie outside of the appointees.
An appropriate legal framework within which the review will be carried out has been decided and is clearly understood by all. This is particularly important where a public report will be produced.
Clear and unambiguous terms of reference are agreed at the outset which are understood by all and strictly enforced.
Those people who are referenced or referred to in the review will be given the opportunity to comment on or amend any reports.
There are no factors, which may give rise to any arguable case of malice, including the conducting of the review itself. Particular attention should be paid to divorcing the form and conduct of the review from any public pressure.

4. Identification and referral for a Safeguarding Adults Review

Any agency, professional, or individual may refer cases to the SAB for consideration of a SAR.

Referrals must be made in writing to the Local Authority Safeguarding Adults Lead or the SAB Coordinator who will ensure that local processes are activated (see Appendix A for referral letter and form).

It is expected that the referral for SAR consideration is made with an appropriate rationale and in a timely manner[2]. A referral does not need to be accompanied by all of the facts of the case.

The Chair of the SAB and the Director of Adult Social Services (DASS) will be notified in the first instance.

The SAR Committee members should then be notified of the referral as soon as is practicably possible and arrangements made for the referral to be considered (an extraordinary SAR Committee may need to be convened).

The Chair of the SAR Committee will need to consider whether case files relevant to the case should be secured immediately to avoid undue delay before the SAR Committee can be convened.

5. The relationship between Section 42 enquiries and Section 44 Safeguarding Adults Reviews

Section 42 enquires are the usual safeguarding adults enquiries that are undertaken when an adult, with care and support needs, has been identified as suffering or being at risk of abuse and neglect[3]. It is not a requirement to undertake a Section 42 enquiry before making a referral to the SAR Committee.

However, a Section 42 enquiry will always be required when there are potentially other adults at risk. The SAR process will not address the immediacy of these risks. For example a SAR referral may be made which relates to abuse or neglect in an organisational setting. The Section 42 enquiry

[2] NSPCC, Serious Case Review Quality Marker: "Referral"

[3] Refer to Safeguarding Adults Policy and Procedure for further information

will be primarily concerned with safeguarding those adults who continue to receive a service from that organisation.

It may be identified as part of an ongoing Section 42 enquiry that the SAR criteria may be met. The decision around whether the SAR criteria has been met is for the SAR Committee and not the Chair of the Safeguarding Adults Meeting/Safeguarding Adults Manager coordinating a Section 42 enquiry.

As stated above, referrals to the SAR Committee should be made at the earliest opportunity and do not need to be accompanied by all the facts of the case. Care should be taken by the Chair/Safeguarding Adults Manager to avoid a Section 42 enquiry encroaching into a Section 44 SAR and therefore the remit of the SAR Committee.

6. Decision

Considering the circumstances of the case will need to be supported by information provided by agencies. An agency involvement form (Appendix C) should be completed by all relevant agencies in preparation for the SAR Committee.

If the decision is to proceed with a SAR, the Committee can use this information to determine the type of review to be undertaken and the scope of the review.

The decision about whether to have a SAR, and the nature of the SAR that is required, will need to take into account factors related to the case and the local context. The pro-forma (Appendix B) should be used to evidence the SAR Committee's discussion and rationale. The rationale for these decisions should be clear, defensible and reached in a timely fashion.

The options are:

- To conduct a SAR using one of the methodologies outlined in Section 7;
- To undertake/request another type of review (e.g. specific agencies to conduct internal management reviews or smaller scale audit/review of agency involvement). In such cases, arrangements should be made for the findings to be shared with the SAR Committee;
- To take no further action.

The decision and recommendation will be made in writing to the Chair of the SAB and will be shared with other SAB members (and the referrer if they are not represented on the SAB) at the next SAB meeting.

Should the referrer disagree with the decision made by the SAR Committee, this should be raised in writing with the Chair of the SAR Committee in the first instance. This will be escalated to the Chair of the SAB if disagreement still exists.

7. Approaches to a Safeguarding Adults Review

The Care and Support statutory guidance states that “the process for undertaking SARs should be determined locally according to the specific circumstances…the focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or have been seriously abused or neglected”.

Best practice suggests that a range of different methodologies should be available to learn from cases. The SAR Committee will need to consider the various options and decide which approach is likely to provide the most learning. The methodology should be proportionate to the presenting circumstances.

Some examples of methodologies which could be used:

- Traditional Serious Case Review;
- Learning Together Review (including focussed/themed review);
- Appreciative Inquiry;
- Peer Review;
- Significant Incident Learning Process (SILP)

All review methodologies outlined have some degree of flexibility. Appendix J includes more information about how each of the above methodologies.

If the SAR criteria has been met, the lead reviewer must be independent of the agencies involved.

Principles that apply to all approaches[4]

- Reviews should not be limited to poor/bad/abusive practice; they should also identify examples of good/excellent practice.
- Reviews should avoid apportioning blame to individuals or agencies involved.
- All reviews should form part of a continuum of auditing and reflective learning, from routine safeguarding practice to serious SARs.
- When trying to understand why a particular action was or was not taken it is important to try and avoid "hindsight bias". This means trying to put yourself in the place of the person or agency at the time they made a particular decision as opposed to this being influenced by what is known with hindsight.
- Attempts should be made to appraise and explain any identified issues. This means thinking about what good practice would have looked like and how did the reality compare?
- Consideration should be given to what contributory factors might have been influencing the decisions and actions that were taken. Contributory factors may include: personal aspects; aspects of the person's job role; aspects of the adult/their family/their circumstances; team factors; conditions of work; inter-agency/inter-professional factors.
- When recommendations or findings are being developed, there should be focus on issues that can be seen to be "underlying" as opposed to issues which are unique to that case. This means thinking about: how embedded the issue is in normal practice; how widespread (team/agency/local area/region/national) is the issue; how often does this type of scenario actually or potentially occur?
- Recommendations should be specific, measurable, attributable, realistic and time-specific. They should be relevant to the practice, procedures and organisational structures in Newcastle, North Tyneside or Northumberland. An author of a report may want to consider producing a list of issues for consideration by the SAR Committee and/or the SAB. The SAR Committee would then be responsible for coordinating and implementing an action plan in response to those issues for consideration.
- Involvement of the adult themselves and/or their family should always be considered and, where appropriate, facilitated.

[4] A number of these principles have been adapted from Social Care Institute of Excellence (SCIE) Learning together to safeguard children. Developing a multi-agency approach for case reviews. SCIE Report 19. (Fish, S. Munro, E. Bairstow, S), 2008

- Front-line staff and immediate line managers should be involved and supported throughout the review process (see Section 11 and Appendix E).
- At appropriate points within the review process, progress should be communicated to the SAR Committee, including the sharing of draft reports and any early-learning which can be acted upon.
- The findings from SARs should be made public and included within the SAB's Annual Report for that year.
- All key statutory SAB partners should contribute to SARs (including provision of funding where this may be required).
- There should be clear terms of reference and governance arrangements for any approach (see Appendix D). Governance will usually be provided by the SAR Committee.

8. Initiating a Safeguarding Adults Review

Where the SAB concludes that a review is appropriate, the SAR Committee will need to coordinate one of the approaches outlined in Section 7. Each approach will require the following considerations (in addition to specific actions/considerations relevant to the approach taken):

- Which agencies and professionals should contribute to the review and who from other sources (e.g. independent sector and/or community and voluntary sector organisations) should be asked to contribute?
- How can the relevant information best be obtained and analysed?
- Are there any features of the case which indicate that any part of the review process should involve, or be conducted by a party independent of the professionals/agencies who will be required to participate in the review?
- Would it be beneficial to involve an external expert?
- Over what time period should events be reviewed?
- Is any background information or family/service history required?
- How will the adult and/or their family be involved in the review? How will they be informed? Before there is contact with the adult and/or their family, a decision should have been made about the level of their involvement in the review.
- How will the alleged perpetrator(s) be involved in the review process?
- Will the case give rise to parallel investigations and if so, how can a coordinated review process best address all the relevant questions in the most economical way?

- How will the review process take into account any criminal investigations or proceedings, or a Coroners Inquiry related to the case? Is there a need to liaise with the Police/Crown Prosecution Service/Coroner?
- What is the timescale for the review process?
- How should the public/adult/family/media interest be handled?
- Does the SAB/SAR Committee need to obtain legal advice about any aspect of the case?

9. Timescales

Whichever approach is taken, the SAR should be completed within six months of the initial decision to proceed unless an alternative timescale has been agreed at the outset.

It is acknowledged that some SARs will go beyond the six month timescale due to the complexity or scale of the enquiry and/or due to ongoing criminal proceedings.

The SAR should be effectively managed. It should run smoothly, be concluded in a timely manner and with available resources. Any delays in the timescales or issues with resources should be communicated to the SAR Committee at the earliest opportunity. Reasons for any delays should be reflected in the final overview report.

10. Involvement of the person or their family

The SAR should be informed by the person or their family's knowledge and experience relevant to the period under review. The person or their family should be told what the SAR is for, how it will work, and the parameters of the review. There will need to be due consideration of the sensitive circumstances surrounding the case.

The SAB will need to give consideration to how best to involve the person or family members and ensure the family will be informed of all findings prior to any publication and release of information.

When contact is made with the person or family, a named person/s (and a deputy) must be identified to answer questions, update the family on

progress and support them on any specific concerns e.g. in the event of media attention, difficult bereavement progress etc.

Information should be provided in a variety of ways. You may wish to use the information included in Appendix F.

Under section 68 of the Care Act 2014, an independent advocate must be arranged (where necessary) to represent and support an adult who is the subject of a SAR if it is judged they would experience substantial difficulty in participating in the review process and there is no other appropriate representative. Where an independent advocate has already been arranged under section 67 of the Care Act 2014 or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate should be used.

SARs should also reflect Making Safeguarding Principles[5].

11. Practitioner involvement

Practitioners and managers from relevant agencies should have a constructive experience of being involved in the SAR[6].

Practitioners and managers who were involved in the case, or potentially should have been involved, are an important source of information for an SAR. Their input is critical to understanding why individuals acted as they did and what was influencing their practice, including routine ways of doing things.

How they experience being involved is important. SARs can be frightening and threatening and employers have a duty of care to all staff, which requires them to provide adequate support. It is the responsibility of SAR Committee members to ensure that their staff involved in the SAR are appropriately supported and informed, particularly around or at the point of the publication of the SAR. Staff are likely to need additional support from their line manager whilst the SAR is ongoing and they should be kept updated on the progress of the SAR.

[5] Social Care Institute of Excellence Making Safeguarding Personal Guide

[6] NSPCC Serious Case Review Quality Markers: "Practitioner Involvement"

Individual learning is also enhanced by practitioners having a positive experience of contributing to the SAR. The broader learning and improvement culture of an organisation is strengthened by good feedback from practitioners who have been constructively involved in an SAR.

Please refer to Appendix E for information which can be provided to practitioners about SARs.

12. The report

The overview report should clearly identify the analysis and findings of the SAR that are key to making improvements, while keeping details of the family to a minimum. Findings should reflect the explanations for professional practice that the analysis has evidenced[7].

As a minimum, the overview report should include:

- Source of referral
- Type of review commissioned
- Rationale for selected methodology
- Period under review
- Timescale for completion
- Reviewer independence
- Demographic information (including ethnicity)
- Clear, specific, and actionable recommendations with clarity on the agencies to which they are directed[8].

13. Communication

Effective communications is an essential part of the SAR process.

Formal notifications about the SAR

When a decision has been made to undertake a SAR, consideration should be given to notifying the following individuals/agencies (as appropriate and dependent upon the case):

- Relevant government departments (e.g. Home Office, Ministry of Justice, Departme of Health and Social Care).
- Elected Leads (Mayor, Leader of Council, Police and Crime Commissioner, Cabinet

[7] NSPCC Serious Case Review Quality Markers: "The Report".

[8] ADASS, Learning from SARs report, 2017

- Local Safeguarding Children Boards, Health & Well-being and Safer Community Partnerships, other Safeguarding Adults Boards.
- Health including Hospital Trusts, CCG's, Specialist Trusts.
- NHS England.
- Care Quality Commission.
- Police.
- CPS.
- Coroner's Office.
- Probation Services.
- Housing.
- Family/ carers/ victim(s) and victim's family.
- Agency / organisation media offices.

A letter (see Appendix G) will be sent to Chief Executives (or equivalents, and copied to SAB representatives) of each agency that has been identified to contribute to the review. This letter will advise them that records relating to the adult(s) concerned need to be secured and requesting their agency's cooperation with the review process (as per section 4 above).

If the case involves the death of an adult then a letter will be sent to the Coroner's Office (Appendix I). This will inform the Coroner that a SAR is being carried out, giving relevant detail such as the parameters of the review and requesting any information from the Coroner's Office which is pertinent to it.

If the criteria for a SAR has not been met, however it has been agreed that a review (of some type) will be undertaken, there is not a requirement to make the above formal notifications. However, this will need to be something that the SAR Committee considers.

Communications planning

The respective Local Authority Communications team will take the lead in guiding SAB's communications requirements in relation to SARs. This will include liaising with communication leads in the SAB's member organisations and initiating and implementing a communications plan where required.

The communications plan for each SAR will take account of communication requirements for a range of audiences/ stakeholders (see table below).

All communications will need to take account of any legal issues – e.g. requirements for information to be published, constraints relating to identification of individuals involved in SARs, ongoing legal action and coroner court proceedings.

Stakeholder	Communication considerations/actions
Person/family	See section 10 above
Practitioners	See section 11 above for practitioners involved in the case. For other practitioners, the SAB will need to ensure learning is widely shared to improve practice. Considerations will need to include: • Update of learning and development programmes to reflect the findings of the SAR. • Publication of short summaries/leaflets with a practitioner focus. • Offering bespoke briefings about the SAR. The above may be single or multi-agency.
Public	The SAB will: • Consider publishing a redacted version of the executive summary and/or overview report of the SAR findings on the respective LA's website (a redacted version is required to protect individuals and families).[9] • Publish an additional statement from the Independent Chair which sets out the recommendations of the SAR, factual information and the action being taken is evidenced as national good practice. • Publish the findings from any SAR in the SAB Annual Report and what actions it has taken, or intends to take in relation to those findings.
Media	As SARs are likely to involve sensitive material around adults at risk of abuse, it is very likely that the media will be interested in the progress and outcome. To facilitate this, the SAB will ensure that communications leads for member organisations are kept up to date on forthcoming reviews.

[9] It is best practice for SABs to publish SAR reports but not a duty to do so. Section 14.177 of the Care and Support Statutory Guidance states that: "The SAB should include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report."

	This will be co-ordinated through the respective Local Authority Communications team. Where it is considered that there could be significant interest in the report of the SAR, it is recommended that a small SAR Communications Group is established at the outset. Its responsibilities will be: • To co-ordinate the communications leads from individual member organisations. • To produce a communications strategy / action plan for the SAR. • To draft and coordinate approval for all communications materials, which may be required, e.g. press statements, production of questions and answers to guide spokespeople for the SAB. • To lead on/ co-ordinate/ support all media activities, including, if required, organising media statements, media briefings, briefing spokespeople etc. • To liaise with other partners to consider potential media issues and responses. • To ensure they are aware of the potential timescales, milestones (e.g. court action, coroners inquests).
SAB Members	All members of the SAB will be kept informed regularly throughout the SAR process. This will be achieved by: • Agreeing a suggested timetable and protocol at the outset of all SARs. • Regular updates at Board meetings. • Sharing the Independent Overview report with all members prior to publication externally. Where specific member organisations are directly involved in the SAR, there is likely to be a requirement for them to be directly involved in communication planning, particularly prior to the publication of a report where public interest may result in close scrutiny of actions. All SAB members have a responsibility to consider the communications requirements of the SAR and support open, honest and transparent communications within any legal

	constraints. Representatives of member organisations of the SAB will be responsible for providing regular feedback on the SAR process, within their own organisations as appropriate.

14. Completing the Safeguarding Adults Review

The final report, findings and/or recommendations will be presented to the SAR Committee in order that the group can agree a final draft.

The SAR Committee will notify the Chair of the SAB and make arrangements for the report to be shared at the next SAB meeting for approval. Where possible, the SAR Committee should have drafted an action plan in response to the findings or recommendations for the SAB meeting. The SAB will need to formally accept the findings and/or recommendations, as well as the accompanying action plan. If the SAB does not accept any of the findings and/or recommendations, the rationale should be clearly detailed in the action plan.

Decisions will need to be made as to who receives copies of full reports (e.g. Overview Report or equivalent). As a minimum, these should be sent to the Chief Executives (or equivalents) of the agencies involved in the review process. See Appendix H for example covering letter.

The SAR Committee will need to decide whether the report will be made public and make a recommendation to the SAB. Publication should be seen as good practice; a decision to not publish should be documented either in the case review report and/or minutes of the SAR Committee. Before it becomes public, the SAR Committee will need to decide how the adult and/or their family and the staff involved will be informed of the contents of the published report. As above, findings from SARs should be included within the SAB's Annual Report for that year.

15. Implementation of the learning

The real value of the completion of a SAR is that relevant professional lessons are learnt and that local multi-agency safeguarding adults practice is improved.

The SABs will ensure that the findings, recommendations and action plans from the review are endorsed at a senior level by each agency. The action plan will indicate:

- Who will responsible for the actions;
- The timescales for completion of the actions;
- The intended outcome of the various actions and recommendations;
- The means of monitoring and reviewing the intended improvements in practice and systems.

The action plan will be a standing agenda item at the SAR Committee until all actions have been completed and progress reported to the SAB.

The SABs will ensure that any learning is shared with front-line practitioners in order that practice can be improved.

The SABs will ensure that learning from the SAR is used to improve multi-agency safeguarding adults policy and procedures and the SAR policy and procedure itself.

Consideration will be given to how the impact of learning will be evaluated.

16. Information sharing and security

It is important to preserve confidentiality. The identified person(s) subject of the SAR will be known as Adult A/B/C etc unless requested otherwise by the person or their family.

Information shared as part of the SAR process is confidential. The information is being shared for the purposes outlined in Section 2.

Where the criteria in Section 3 have been met, there is a statutory requirement for agencies to cooperate and to share information in order to undertake a SAR (Section 44 and 45, Care Act 2014).

Where the criteria in Section 3 have not been met, but a decision is made to undertake a review of the case, the SAR Committee will need to ensure that information is shared fairly and lawfully in line with the Data Protection Act (General Data Protection Regulations from 25 May 2018).

The documents and information produced for a SAR are the property of the relevant SAB, this includes any Individual Management Review reports. Requests for copies of documents or information produced for a SAR should be directed to the Local Authority Lead for Safeguarding Adults and should be made in writing, detailing the purpose for which the information is requested. The request will be discussed with the SAR Committee, the Chair of the SAB, the Director of Adult Social Services and a legal adviser before any disclosure is made.

The disclosure of information relating to the SAR will be a rare occurrence, but may be necessary; for example to support the criminal justice process.

Records relating to SARs will be retained for a period of six years following the publication of the SAR or the 25th anniversary of the subject's birth[10] (whichever is later). At this point, the files relating to the SAR would be reviewed before destruction to determine whether further retention was required. Further retention may be required for a variety of reasons, including: information becoming more significant in the light of later events or the likelihood of future legal proceedings by anyone involved[11]. The decision to destroy or further retain records relating to a SAR will be approved by the SAR Committee (and supported by legal advice). If the decision is to proceed with destruction, all agencies who may be retaining duplicate records will be notified in order for them to consider whether to delete or amend their own records.

The respective SAB Information Sharing Agreements should be followed in relation to the secure storage and transfer of information relating to the SAR.

[10] Under the Limitation Act 1980, there is generally a statutory limitation period of 6 years in which civil claims may be instituted. This time period does not start to run until age 18. The suggested retention periods are in accordance with this limitation period.

[11] See R (C) v Northumberland County Council [2015] EWHC 2134

Appendix (A)

STRICTLY PRIVATE AND CONFIDENTIAL

FAO Local Authority Safeguarding Adults Lead
(Name of Authority)
(Address)

Date:

Dear < Local Authority Safeguarding Adults Lead >

REFERRAL FOR A SAFEGUARDING ADULT REVIEW

Re: *Service User name* (*include any known aliases) Date of Birth, Address*

I wish to refer the above case to the Safeguarding Adult Review Committee for consideration under the North of Tyne Safeguarding Adult Review Policy and have completed the attached Consideration Request Form.

I understand that the case will be discussed by the Safeguarding Adult Review Committee, and a recommendation made to the Independent Chair of the Safeguarding Adult Board and The Director of Adult Social Services. I understand that I will be notified of the decision in due course.

Yours faithfully

(Name)
(Designation)
(Address)
(Telephone number)
(Email address)

Consideration Request Form for a Safeguarding Adult Review

Version 3
January 2015

Please complete if you believe that the criteria for conducting a Safeguarding Adults Review (SAR) (Section 44, Care Act 2014) has been met. Please include as much information as you can and forward to Local Authority Lead for Safeguarding Adults as password protected document or via another secure route.

Referrer (Name, Agency and Contact Details)		**Authorised by Senior Officer / SAB Board Member (Name and Contact Details)**	
Date			

ADULT'S DETAILS

Family Name:		**Given Name:**		**Also known as:**	
DoB		Gender: Male ☐		Female ☐	
Home Address (include Postcode):					
Care Manager:		**Practice / Team Manager:**			
Health Worker:		**Carer:**			
GP's Name & Address:					

ASSOCIATED PEOPLE (i.e. OT, Physio, Police, Probation, Voluntary Agencies)

Date, brief details of incident, agencies involved and why consideration is required	

N.B. FOR SAB ACTION:

Date received		**SAB Chair/DASS Notified of Request**	
Panel meeting arranged for:			
Panel notified and documents sent out			

Appendix (B)

Safeguarding Adult Review Committee Discussion Regarding Agency Involvement with Adult, Relevant Others and Incident(s)

Date of Meeting:

Agencies Present:

Apologies:

Purpose of Meeting:

Recommendations:

Criteria for Considering a Safeguarding Adults Review

Q1 Is the subject an adult with care and support needs?	Yes	No
Q2 Is abuse or neglect known or suspected?	Yes	No
Q2 Has an adult died (including death by suicide) **or** has an adult suffered serious abuse and neglect and there is reasonable cause for concern as to the way in which the SAB, members of it or other persons worked together to safeguard the adult.	Yes	No

Where the criteria for a Safeguarding Adults Review are not met, SAB should consider:

- Whether they should commission an alternative form of Safeguarding Adult Review;

- Cases which do not meet the Safeguarding Adults Review criteria where there are still lessons to be learned or instances of good practice, and consider how these can be shared and embedded. SAB's are free to decide how best to conduct these reviews. The SAB's should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

- The decision to undertake a Safeguarding Adults Review should normally be made within one month of notification of the incident.

- SAB responsibility:
  Where partner agencies of more than one SAB have known about or had contact with the adult, the SAB for the area in which the adult is/was normally resident should take lead responsibility for conducting any review. Any other SAB's that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the review.

Where an adult with care and support needs has died or has been seriously harmed answering 'yes' to several of the following questions is likely to indicate that a review could yield useful lessons and help inform what type of review should be considered.

Record response from Safeguarding Adult Review Committee Members	**Yes/No**	**Rationale**
1. Was there clear evidence of a risk of significant harm to the adult which was not recognised and acted upon appropriately by an organisation or individuals in contact with the adult or perpetrator.		
2. Was the adult abused or neglected in an institutional setting (e.g. Care Home, Day Centre, Prison, Hospital, Hospice, Respite Care)?		
3. Has the adult recently moved to the locality?		
4. Did the adult suffer harm during an unauthorised absence from an institution or having gone missing from home or another care setting?		
5. Does one or more agency or professional involved with this case or cases consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?		
6. Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult procedures, which go beyond the handling of this case?		
7. Was the adult current to safeguarding or had they previously been subject to safeguarding arrangements?		
8. Does the case appear to have implications for a range of agencies and/or professionals?		
9. Does the case suggest that the SAB or other agencies may need to change their local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?		
10. Are there any indications that the circumstances of the case may have national implications for systems or processes or, that it is in the public interest to undertake a Safeguarding Adult Review?		

Criteria for Safeguarding Adults Review met:	**Yes**		**No**	

Does this case meet the SAB responsibility criteria for SAB to take lead responsibility? **Yes** ☐ **No** ☐

If no, which if any SAB should? _____

Alternative Process Proposed:	**Yes**		**No**	

Methodology to be used and reason:	
Lead Agency:	
Co-ordinator Contact Details:	
Agencies to be involved in Review:	
Date submitted to SAB Chair and Chairs Decision:	

Appendix (C)

Safeguarding Adults Review – Agency Involvement Form

Case for Consideration by <insert relevant SAB name>
For a Safeguarding Adults Review

Sections 1 and 2 to be completed by Strategic Safeguarding Adults Manager.
Sections 3 and 4 to be completed by individual agencies.

1 Identifying details

Adult Subject(s)	Address	DOB

Relevant family members:	Address	DOB

2 Brief outline of case

3 Person and agency completing this form

4 Summary chronology of agency involvement

Please detail key contacts and summary of involvement – a full chronology is not required at this stage.

Date (dd/mm/yyyy)	Contact

5 Any other relevant information or comments

Appendix (D) – Example Terms of Reference

The following is an example of a Terms of Reference for a SAR. It is intended as a guide and should be adapted to suit the case.

Newcastle Safeguarding Adults Board
Safeguarding Adults Review

Terms of Reference

1. Introduction

A decision was made by the XXXX Safeguarding Adults Board to undertake a Safeguarding Adults Review on XXXX following the death/serious harm of an adult with care and support needs. For the purposes of this document, the adult will be referred to as Adult X. Adult X was aged X when they died. The Safeguarding Adults Board has a statutory duty to undertake Safeguarding Adults Reviews under section 44 of the Care Act 2014.

2. Agencies involved

The following statutory agencies were involved with Adult X:
XXX
Other agencies who may contribute to the Safeguarding Adults Review:
XXX

3. Case summary

<provide brief summary of the case>

4. Purpose of the Safeguarding Adults Review

The purpose of having a Safeguarding Adults Review is not to reinvestigate or to apportion blame, undertake HR duties or establish how someone died. Its purpose is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local inter-agency practice;
- To improve practice by acting on learning (developing best practice);
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

There is a strong focus on understanding the underlying issues that informed agency/professionals' actions and what, if anything prevented them from being able to properly help and protect XXXX from abuse.

Further information can be found in the Safeguarding Adults Review Policy and Procedure <hyperlink to local webpage/document>.

5. Terms of Reference: Key case issues

At a meeting on XXX, the following key issues were agreed as being important and which should be considered within the SAR: <delete/amend/expand as appropriate to reflect the key lines of enquiry>

- Were practitioners sensitive to the needs of Adult X in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?
- Did your agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare?
- What were the relevant points or opportunities for risk assessment and decision making in this case in relation to Adult X? Do the assessments and decisions appear to have been reached in an informed and professional way?
- Did action accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments? Does it appear that all legal options were explored to safeguard the adult at risk?
- Where relevant, were appropriate Safeguarding Adults Plans (protection plans), risk assessments or care plans in place and were these plans implemented? Were there any factors present that prevented these plans being implemented successfully? Had review processes been complied with?
- Did your agency have any information to suggest that Adult X was being abused or neglected? If so, was this information appropriately acted upon?
- When, and in what way, were Adult X or his family's wishes, feelings and views ascertained, considered and acted upon? Did action accord with the views expressed? Was this information recorded?
- Was practice sensitive to any protected characteristics of Adult X?
- Were senior managers, or other agencies and professionals, involved at points where they should have been?
- Was work in the case consistent with agency and SAB policy and procedures for protecting adults at risk and wider professional standards?
- Please comment on any aspects of the case or the agency involvement that are examples of good practice.
- Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?
- What are the lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?
- Are there any aspects of SAB policy and procedures that need to be reviewed as a result of this case?
- Were staff provided with appropriate training in relation to safeguarding adults? Does it appear that training has impacted upon practice?

It was agreed that the timeframe for the Safeguarding Adults Review would be **XX – XX**. <insert any reasoning behind choosing this timeframe>

Any information from before this timeframe will be used to provide background information for this Safeguarding Adults Review.

<State whether the review will consider/explore information relating other individuals not subject to the SAR e.g. alleged perpetrators>.

6. Process for undertaking Safeguarding Adults Review

Provide a summary of the methodology chosen and any key activities/events/stages of the SAR, including dates where possible.

7. Safeguarding Adults Review Panel Membership <if established>

A panel will be established that will oversee the Safeguarding Adults Review for Adult X. The panel's role will be to quality assure the process and products (including IMR reports and the final overview report). Panel members need to be of sufficient seniority to be able to provide challenge as well as agree any recommendations.

The Safeguarding Adults Review Panel's membership will consist of:

- All those agencies completing IMRs (representative may be SAR Committee member OR IMR author OR other nominated senior member of staff)
- Specialists in XX
- A legal advisor

8. Involvement of Adult X or their family

Adult X's/family have been notified of the intention to undertake a Safeguarding Adults Review. Adult X's/family will be fully involved in the Safeguarding Adults Review to the extent that they wish. <Add any further details specific to the case about the adults/family involvement>

9. Involvement of key staff and volunteers

The review will seek to hear the perspectives of all key staff and volunteers by <insert how this will be done>.

The SAR Committee/Panel member from each agency is responsible for identifying and notifying relevant staff and volunteers of this SAR and facilitating their involvement.

The SAR Committee/Panel member from each agency is responsible for ensuring relevant staff and volunteers are provided with a safe environment to discuss their feelings and offered emotional support where needed, including counselling or other therapeutic support.

10. Coroner and Crown Prosecution Service (CPS) considerations

The Coroner has been notified of the intention to undertake a Safeguarding Adults Review and is happy for the review to proceed. The Coroner's Inquest will not take place until criminal proceedings have concluded. Terms of Reference will be shared with the Coroner and any other information as requested/necessary. <Only applicable if the adult has died>

The Police have agreed that the Safeguarding Adults Review can proceed alongside any possible criminal proceedings. The Independent Reviewer and Safeguarding Adults Review Committee will liaise with the Senior Investigating Officer to ensure that the criminal process is not jeopardised. The Senior Investigating Officer will liaise with the CPS. <Amend as appropriate>

11. Safeguarding Adults Review timescales

The review should be completed within six months as per the timeline outlined above in section 6. This timescale may be subject to change depending on any impact of criminal proceedings.

12. Communications

XX Council are the lead agency in relation to communications about Safeguarding Adults XX Council. Any approaches made to other agencies should be directed to XX Council. There will be no public statements about the Safeguarding Adults Review until criminal proceedings have concluded.

Other key stakeholders that will need to be updated as appropriate:

- …
- …

13. Links to other review processes

Identify any other review processes (e.g. SCR, DHR, SUI, LeDeR) of relevance to the case and arrangements for coordinating these processes and ensuring learning is shared.

Appendix (E)

Guidance for staff about Safeguarding Adults Reviews

1. Who will speak to me, and why?
This will be dependent upon the approach used to review the case. It could be a manager from your agency appointed to write the agency management review report or it could be someone independent of your organisation.

They will usually ask you to expand on information contained in files or to clarify what you have recorded. This interview generally focuses on facts and actions, and the person speaking to you will not question you on issues of your performance, as this is a matter for your managers. Notes will be taken of the questions asked and responses received.

Safeguarding Adults Reviews enable all partner agencies to identify any lessons that can be learned from particularly complex or difficult safeguarding adult cases and implement changes to improve services in the light of these lessons

Note: People undertaking Safeguarding Adults Reviews have a duty to report any concerns about practice or risk to adults or children that may become known in the course of review.

2. Can I bring someone with me to the interview/conversation/discussion?
You can bring a colleague, union representative or other supportive person with you if you wish.

3. What happens to the information I give?
It is noted down, and a copy given to you for checking and correction if required. The notes are to assist in compiling an accurate account of the agency's actions. They would not be shared with other agencies or be appended to any other report.

Note: Although great care is taken to avoid identifying individual staff by name in reports, it is sometimes the case that staff may be identified by some other means, such as being named by the service user, or simply by being the key worker for the case.

Any report produced for the purposes of a Safeguarding Adults Review must look openly and critically at individual and agency practice. However, at the end of the Safeguarding Adults Review process, it is the agency that is held accountable for all the actions taken by its staff, and they must address all issues of concern, such as practice and performance issues of staff, training and policy deficits.

4. How will I be kept informed of what is happening in the case?

4.1 **Information:** Your agency representative (usually a Senior Manager) is responsible for keeping staff informed, where appropriate and relevant, of what is taking place in the Review process.

4.2 **Support:** Your Manager should also have relevant information, and will assist and support you as required. Your manager may need to consider arranging additional support for you, e.g. counselling. Depending on the circumstances of the case, it is possible that another person will be appointed to the role of providing support and information instead of your Manager.

4.3 **Managerial follow up:** When the report has been completed, you will be able to read it, and suggest amendments or corrections. You will have the chance to reflect on the learning that has been identified. You should be able to contribute to the recommendations that are made.

4.4 **Good practice:** This will be identified in the Safeguarding Adults Review and shared with others in your agency.

4.5 **Feedback:** At the end of all the formal processes, when the Safeguarding Adults Review has ended, feedback will be given to you and other staff. This may be done on an individual basis, for example where interviews have taken place, or in groups. Sometimes large-scale staff briefings may be held.

The Action Plan that must be implemented across agencies will also be shared with staff.

Appendix (F) – amend as appropriate

Safeguarding Adults Review
Information for families

What are Safeguarding Adults Reviews?

Safeguarding Adults Reviews are one way to improve responses to the abuse or neglect of adults at risk. They aim to help prevent what happened to <you/your family member> happening to others.

They will try to ensure that public bodies like councils, police, health services and other organisations understand what happened before the <death/serious harm> of <you/your family member> and identify where responses to the situation could be improved. From this, the public bodies hope to learn lessons, including how organisations can work better 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 responses to safeguarding adults situations in the future.

Safeguarding Adults Reviews are part of the Care Act (2014) and became law from 1 April 2015. They do not replace but will be in addition to a Coroner's inquest or any other form of inquiry.

Who will undertake the review?

A review team will be formed of senior staff from the organisations who had involvement with <you/your family member>, but it will not include anyone who has been directly involved in the case. The review team will look at how the response to abuse or neglect of adults at risk could be improved to help better support victims.

Your involvement in the review

We think <you/friends, family members and other people who knew the victim> are the best people/person> to help the review team understand what happened. <Victims often tell their family about the abuse they suffered and, sometimes, about their experiences in asking for help>. <You/Family members> can help public bodies to identify what lessons should be drawn from this tragedy, so your <voice(s)> 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 <serious harm/death of you/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 that <you or your family member(s)> made to seek help from public bodies, community organisations and others because sometimes not all of these contacts are known to the 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 not be asked to share your thoughts under oath. The reviewer 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 detailed picture of what happened before the <serious harm/death of you/your family member> and in turn will help the team make 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 if you do not want to be.

Your contribution will be valuable and may help change the way the community, including public bodies, respond to victims of abuse and neglect.

Confidentiality
It is important that any information that is shared with you about the Safeguarding Adults Review is kept confidential. This is to ensure that any criminal proceedings are not affected.

How long will the review process take?

There is no set time frame for a Safeguarding Adults Review but it is anticipated that it should be completed within about six months. It could be longer depending on the outcomes of other inquiries, for example, any ongoing criminal proceedings against the perpetrator(s). You should be informed of any delays.

What does the review produce?

- A detailed, anonymised, report and summary of that report. This will be available on a public website.
- An action plan to ensure any recommendations made in the report are 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 in the letter attached to this leaflet. They will either answer your questions or direct you to someone who can.>

Appendix (G) – Example letter following decision to commission an SAR

Notification of Safeguarding Adults Review Request

Dear Colleague

Safeguarding Adult Review for:

Name
Address
Date of Birth

The Safeguarding Adults Board is required to convene a Safeguarding Adult Review in relation to the above-named person as it is suspected that abuse or neglect may have been a factor in this case.

Please ensure that all written and electronic records held by your agency for the above named person and others directly involved, are made secure and are only accessible to a senior manager nominated by your agency's responsible Executive, the Police and the nominated Safeguarding Adult Review Investigating Officer.

You will be contacted at a later stage with further information on this matter.

A full account of the Newcastle, North Tyneside/Northumberland Safeguarding Adults Board Safeguarding Adult Review process can be found on the council websites under Adult Safeguarding.

Thank you for your co-operation.

Yours sincerely

Chair of the Safeguarding Adults Review Committee

Appendix (H) – Example letter following conclusion of SAR

Notification of Safeguarding Adults Review Conclusion

Date:

Dear Colleague

Safeguarding Adult Review for:

Name
Address
Date of Birth

The Safeguarding Adults Board convened a Safeguarding Adult Review in relation to the above-named person as it was suspected that abuse or neglect may have been a factor in this case.

The Board has now concluded their findings and will continue to monitor the outcomes of partner agencies actions to address the lessons learnt from the findings.

The case conclusion is approved by the Executive sign off processes as set out in the North of Tyne Safeguarding Adult Review Policy.

The SAB would like to thank you for over-seeing the action provided by your agency.

Yours sincerely

Chair of the Safeguarding Adults Review Committee

Appendix (I) – Example letter to coroner

Notification of Safeguarding Adults Review
Date:

Dear Coroner

Safeguarding Adult Review for:

Name
Address
Date of Birth

The SAB Safeguarding Adults Review Committee considered the above case to decide whether it met the criteria to initiate a Safeguarding Adults Review. The Committee feels that this case does meet the criteria to commence a Safeguarding Adults Review.

Please could you confirm, or otherwise, any Coroner's proceedings which may be need to be taken into account by the Safeguarding Adults Review Committee when planning the Safeguarding Adults Review?

Please don't hesitate to contact me if you have any queries or concerns in relation to this case.

Yours sincerely

SAR Committee Chair

Appendix (J)

Suggested processes/more information about the different methodologies and approaches available

Each SAR will be different, the following information is intended to be a guide only.

Traditional Serious Case Review

In this option the traditional Serious Case Review (SCR) methodology is followed, where individual agencies submit chronologies and produce an Individual Management Review (IMR)

Process	Suggested Timescale
The SAR Committee decides SAR criteria has been met and that a traditional SCR methodology will be used.	Within a maximum of one month of submission of referral to LA Safeguarding Adults Lead/SAB Coordinator.
The Chair of the SAR Committee makes a recommendation to the Chair of the SAB who makes a joint decision with the DASS (Director of Adult Social Services) to commission an independent report.	Within a maximum of two weeks of the SAR Committee decision to recommend a Safeguarding Adults Review.
The LA Safeguarding Lead/SAB Coordinator identifies an Independent Overview Report Writer (and Chair if required).	Within a maximum of one month of the SAB Chair/DASS approval (to enable appropriate commissioning arrangements).
The SAR Committee meets to agree the terms of reference for the Safeguarding Adults Review and Individual Management Reviews (IMRs) and agree those agencies who need to identify IMR authors.	Within a maximum of two weeks of appointment of the Independent Overview Report Writer.
First meeting of IMR authors with the Independent Overview Report Writer (and chair if appointed).	Within a maximum of two weeks after the SAR Committee have met to agree the terms of reference.
Submission of chronologies and IMRs (See Appendices K and L for templates) to SAR Committee /Independent Overview Report Writer.	Within six weeks of the first meeting of IMR authors.
Production of draft Overview Report	Within six weeks of the submission

and second meeting with IMR authors to finalise the draft.	date of the IMRs.
Production of the final Overview Report –final approval of SAR Committee	Within two weeks of the second meeting of IMR authors.
Presentation of the Overview Report to the SAB. *SAB may also request an Executive Summary.*	To be submitted to the first SAB that is scheduled following approval of the Overview Report by the SAR Committee.
SAR Committee agrees communication plan with SAB.	Within one week of the SAB agreeing the final report.
SAR Committee produces an action plan.	Within three months of completion of Safeguarding Adults Review.
SAR Committee reviews the actions and recommendations to ensure implementation. Progress is reported to the SAB.	No more than six months after the completion of the review.

Appendix K provides more guidance around the completion of IMRs.

Learning Together review

This is a systems-based approach to reviewing a case. Learning Together reviews are conducted by a multi-agency 'Review Team' which is led by two Lead Reviewers (accredited by the Social Care Institute of Excellence (SCIE)). This approach provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to be mistaken or to have led to an unwanted decision, seemed to those involved, to be the sensible thing to do at the time.

Process	Timescale
The SAR Committee decides SAR criteria has been met and that a Learning Together Review will be used.	Within a maximum of one month of submission of referral to LA Safeguarding Adults Lead/SAB Coordinator.
The Chair of the SAR Committee makes a recommendation to the Chair of the SAB who makes a joint decision with the DASS (Director of Adult Social Services) to commission an independent review.	Within a maximum of two weeks of the SAR Committee decision to recommend a Safeguarding Adults Review.
Decision is fed back to LA Safeguarding Adults Lead/SAB Coordinator and the Chair of the SAR	Within one week of receiving the recommendation.

Committee	
The LA Safeguarding Adults Lead/SAB Coordinator. contacts SCIE to appoint two Lead Reviewers.	Within a maximum of one month of the SAB Chair/DASS approval (to enable appropriate commissioning arrangements).
SAR Committee meets to identify who should be a part of the 'Review Team' who are managers/senior managers representing the agencies involved in the case. Members of the Review Team play a key role in the review, including talking to staff, reviewing documentation and analysing data, identifying and priorities revealed by the case. Review Team members should not have had any decision-making role in the case being reviewed.	Within a maximum of two weeks of appointment of the Lead Reviewers.
Introductory and scoping day for Lead Reviewers and Review Team Members (and other interested SAR Committee /SAB members).	Within a maximum of two weeks after the SAR Committee have met to agree the 'Review Team'.
Initial planning meeting for Lead Reviewers and Review Team.	Within two weeks of the introductory and scoping day.
Introductory meeting for Case Group (staff involved in the case), facilitated by Lead Reviewers/Review Team.	Within four weeks of introductory and scoping day.
Individual conversations (Review Team meet with staff involved in the case).	To be completed within four weeks of Initial Planning Meeting for Lead Reviewers and Review Team.
First analysis meeting (conversations) with Review Team to agree Key Practice Episodes (KPEs) in the case.	Within two weeks of conclusion of initial conversations.
Lead Reviewers start to write the report for the first follow on meeting (see below)	
Second analysis meeting with Review Team (documentation) to review and discuss data/documentation and check draft report.	Within four weeks of first analysis meeting.
First follow on meeting for Lead Reviewers and Review Team to share emerging analysis with Case Group so	Within four weeks of second analysis meeting.

they can check accuracy, answer further questions, challenge and/or amplify interpretation.	
Third analysis meeting for Lead Reviewers and Review Team to discuss underlying patterns and their prioritisation.	Within two weeks of first follow on meeting.
Second follow on meeting for Lead Reviewers and Review Team to share the generalised learning with the Case Group and get their input about the underlying patterns that have been identified.	Within two weeks of the third analysis meeting.
Fourth and final analysis meeting. To include SAR Committee to sign off the report and plan how to present to the Board.	Within four weeks of the second follow-on meeting.
Presentation of the report to the SAB.	To be submitted to the first SAB that is scheduled following approval of the report by the SAR Committee .
SAR Committee agrees communication plan with SAB.	Within one week of the SAB agreeing the final report.
SAR Committee produces an action plan.	Within three months of completion of Safeguarding Adults Review.
SAR Committee reviews the actions and recommendations to ensure implementation. Progress is reported to the SAB.	No more than six months after the completion of the review.

Appreciative Inquiry

The Appreciative Inquiry approach asks generative open questions about what worked well, alongside what might and should be different in the future.

Process	Timescale
The SAR Committee decides SAR criteria has been met and that an Appreciative Inquiry will be used.	Within a maximum of one month of submission of referral to LA Safeguarding Adults Lead/SAB Coordinator.
The Chair of the SAR Committee makes a recommendation to the Chair of the SAB who makes a joint decision with the DASS (Director of Adult Social	Within a maximum of two weeks of the SAR Committee decision to recommend an Appreciative Inquiry.

Services) to commission an Appreciative Inquiry.	
Decision is fed back to LA Safeguarding Adults Lead/SAB Coordinator and the Chair of the SAR Committee.	Within one week of receiving the recommendation.
The LA Safeguarding Adults Lead/SAB Coordinator arranges a facilitator(s) skilled in the Appreciative Inquiry approach. If the SAR criteria has been met, the facilitator(s) must be independent of the agencies involved.	Within a maximum of one month of the SAB Chair/DASS approval.
Planning meeting between the facilitator(s) and LA Safeguarding Adults Lead/SAB Coordinator to agree scope for review and who will need to be involved.	Within a maximum of two weeks of being appointed.
Scope of review and list of participants approved by SAR Committee.	Within a maximum of four weeks after the planning meeting.
Letters and background information sent out to participants.	Within two weeks of the SAR Committee approval of scope and participants.
Appreciative Inquiry Review meeting held. Meeting has six stages: 1. Introduce themselves and their best strengths in challenging times. 2. Inquire into one another's work with the individual, asking about: i) those interventions that were successful in keeping them safe; ii) those things that with the benefit of hindsight should have been done differently. 3. Create a multi-agency timeline story by sharing practitioner's answers to the two questions above. 4. Reflect together on all the things that worked well, and all the areas that people could now see should have been done differently. 5. Seek new ideas about the redesign of those things that must change to enable the whole system to get	Within six weeks of letters being sent out to participants. The length of the meeting is dependent on the case and could range from half a day through to two or more days.

better at keeping adults safe. 6. Make individual and shared commitments to on-going development, action and change.	
Report drafted by Appreciative Inquiry facilitators.	Within six weeks of Appreciative Inquiry Review meeting.
Draft report shared with participants for their comments/amendments.	Within four weeks of report being shared.
Final draft report shared with SAR Committee. Report agreed and signed off by SAR Committee.	Within four weeks of deadline for comments/amendments.
Presentation of the report to the SAB.	To be submitted to the first SAB that is scheduled following approval of the report by the SAR Committee.
SAR Committee agrees communication plan with SAB.	Within one week of the SAB agreeing the final report.
SAR Committee produces an action plan.	Within three months of completion of Safeguarding Adults Review.
SAR Committee reviews the actions and recommendations to ensure implementation. Progress is reported to the SAB.	No more than six months after the completion of the review.

Significant Incident Learning Process (SILP)

SILP explores the professional's view of the case at the time the events took place. It analyses significant events and deals not only with what happened but why it happened. SILP can show us what affected the practitioner's actions and decision making at the time and what needs to change.

The SILP approach is rooted in systems methodology, with each review being scoped to offer a proportionate approach according to the requirements of the case. Families and significant others are offered opportunities to engage with the reviews in a variety of ways. SILP reviews see equal value in learning from good practice.

Peer review

This option accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same

safeguarding partnership, (for instance SAB members), or other local authority areas.

Peer led reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. They can be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this option regarding the balance of peer team, for instance from one authority area, to a range of different people across various agencies to maximise identified expertise.

Likewise, there can be flexibility regarding the exact methodology to be adopted in order (see options above) to achieve the desired outcomes of the SAR.

The appointed peer team/panel should agree the terms of reference with the Safeguarding Adults Review Committee.

Referral to another SAB sub-group/committee

Some SABs have an existing sub-group/committee that would be in a position to review a case. It is unlikely that this option would be used to review a case meeting the SAR criteria. However, it may be an option when the SAR criteria has not been met.

Process	Timescale
The SAR Committee considers the Safeguarding Adults Review referral. Agencies complete Agency Involvement Form (Appendix B).	Within a maximum of one month of submission of referral to LA Strategic Safeguarding Manager.
The Chair of the SAR Committee makes a recommendation to the Chair of the SAB who makes a joint decision with the DASS (Director of Adult Social Services) to review the case using a sub-group/committee.	Within a maximum of two weeks of the SAR Committee decision to recommend the review the case.
Decision is fed back to Strategic Safeguarding Adults Manager and the Chair of the SAR Committee	Within one week of receiving the recommendation.
The LA Strategic Safeguarding	Within a maximum of one month of the

Manager arranges a case summary to be compiled by best placed person (e.g. someone who has significant knowledge of case – lead professional, Safeguarding Adults Manager).	SAB Chair/DASS approval.
Process	Timescale
Case summary submitted to Chair of Sub-Committee/Group for consideration at the next meeting. Case presented by author of case summary. Sub-Committee/Group identify good practice and any areas where practice needs to be improved. Consideration as to whether a Task and Finish Group needs to be set up to consider case in more detail.	At next sub-Committee/Group meeting
Chair of Sub-Committee/Group presents findings/recommendations to SAR Committee. Action plan developed.	At next SAR Committee following other sub-Committee/Group meeting.
Report and action plan (as appropriate) shared with SAB.	To be submitted to the first SAB that is scheduled following SAR Committee.

Appendix (K)

Guidance for completion of Individual Management Reviews

Once a decision has been made to undertake a SAR where Individual Management Reviews (IMRs) form a part of the review process (e.g. traditional serious case review approach), each agency will be asked to:

- Appoint a senior manager from within their organisation (or an independent person) to undertake the task of authoring the IMR and compiling the relevant report for the Overview Report author/SAR Committee. This manager should not have been directly concerned with the adult(s) at risk, or be the immediate line manager of the practitioners involved.
- Appoint an **Authorising Senior Manager** from the organisation to accept the IMR report and ensure that the recommendations are actioned on behalf of the organisation.
- Ensure that all relevant files are secured and made available to the organisation IMR report author.
- Ensure that IMR report authors are allocated adequate resources (time, admin support) to complete their report within the required timescales (**usually 6 weeks**). It is imperative that timescales are adhered to in order that the role and actions of the agencies involved with the adult(s) at risk can collectively be reviewed by the SAR Committee.
- Make available to the IMR Report Writer, the Chronology template and the IMR template, (compiled by the SAR Committee) which must be used for the compilation of the IMR. Further guidance is contained within these templates.
- Ensure that any staff involved with the adult(s) at risk should be given the opportunity to discuss their understanding of what has happened. It is essential that support and counselling be offered, given the possible serious impact on the professionals involved. Staff should also be given a copy of Appendix D which provides information/guidance on SARs. Support should be ongoing and reviewed regularly by the line manager.
- Consider whether there is any evidence for a disciplinary investigation (see below).

Role of Individual Management Review report authors

- The report author, having reviewed the files, should then be aware of the members of staff who have been involved in the case. The staff members, through their line manager, should already be aware that a Safeguarding Adults Review is being undertaken.
- Even if the report writer is satisfied that the files contain all the relevant information he/she should meet with the professionals from their organisation who have had recent or relevant involvement with the adult(s) at risk. This should be arranged in consultation with the staff member's line manager. The report author should ascertain, in consultation with the line manager, that the member of staff is receiving or has received the appropriate support in relation to that member's own welfare.
- This meeting should give the report author the opportunity to check with the member of staff the factual accuracy of the details of the chronology. It will also be an opportunity for staff to identify any lessons they consider can be learnt from their own and their organisation's involvement. A written record of the interview should be made and should be shared with the interviewee.
- The purpose of the IMR is to look openly and critically at individual and organisational practice, to see whether the case indicates that changes could or should be made and, if so, to identify how those changes will be brought about.
- Good practice should be highlighted in the report.
- The IMR report author should complete the chronology and report on the relevant template, and a copy should be sent to the **Authorising Senior Manager** in their organisation for their

acceptance on behalf of the organisation, before it is forwarded to the LA Strategic Safeguarding Adults Manager by the deadline specified, who will arrange for it to be forwarded to the SAR Committee. The **Senior Manager** within the organisation will be responsible for ensuring that the recommendations contained within the IMR are acted on.

NB. If the report author has any difficulty in carrying out the above tasks then he/she should contact either the Safeguarding Adults Lead within the Local Authority or the Chair of the Safeguarding Adults Review Committee.

Criminal proceedings

- There may be a criminal investigation running concurrently with the Safeguarding Adults Review. In situations where there may be conflict between the two processes, the criminal investigation takes precedence although this should not delay the work being undertaken in respect of the Safeguarding Adults Review. In such cases, IMR authors will be advised by the Safeguarding Adults Review Committee of any necessary changes to the above guidance.

Other review processes

- Some cases may be subject to other forms of review, for example a critical incident review or a Domestic Homicide Review. In this situation IMR report authors are advised to contact the other reviewers to avoid duplication and to ensure a coherent approach to each review.

Disciplinary action

- If an organisation decides at any stage of the Safeguarding Adults Review process that disciplinary proceedings need to be initiated then the line manager will need to discuss with the IMR report author the appropriateness of proceeding with a discussion with the relevant staff members.
- If the IMR report author comes across information which he/she considers is a matter which needs to be investigated under disciplinary procedures then this should be brought immediately to the attention of the agencies senior manager.

Appendix (L)

Safeguarding Adults Review: Agency Chronology of Involvement

Name of agency:
Name of adult:
Name of person completing chronology:

(please add further rows to the table as required)

Date	Source of evidence	Contact with	Initials of professional(s)	Reason	Incident/contact location and type	Action taken/decision made/outcome	Comment
Use dd/mm/yyyy format	Note agency plus source within agency e.g. GP records	Use initials and clarify who they are e.g. alleged victim, alleged perpetrator, neighbour etc	Anonymised initials of the professional(s) involved, job role and agency (if different to own) with the contact	Reason for contact	Where did the contact happen and how did it occur e.g. home visit, telephone call	What happened as a result of the contact?	Any comment from the agency reviewer on the appropriateness/ quality of the intervention. May assist to form view for analysis

Appendix (M)

IMR Template

Safeguarding Adults Review: Individual Management Review

Name of agency:
Name of adult:
Date of Birth of adult:
Date of Death of adult:

Name and contact details of person completing IMR:

Factual/contextual summary
Provide a brief factual and contextual summary of your agency's involvement with <Adult(s) X>. This does not need to be a repetition of the chronology and should be a summary only.

In addition to the chronology timeframe, please also include any information you have about your agency's contact between <insert relevant dates>, in particular to: <insert any specific areas of enquiry the Safeguarding Adults Review Committee/Overview Report Writer wish to pursue>.

Chronology of agency involvement
To be completed on the chronology template provided.

What was your agency's involvement with <Adult(s) X> and/or alleged perpetrator?

Construct a comprehensive chronology of your involvement by your agency and/or professional(s) in contact with <Adult(s) X> and/or alleged perpetrator between <insert relevant dates>. Where abbreviations are used, please provide a glossary at the end of the chronology to explain them.

Names of staff members should not be used but use anonymised initials and job roles eg AA – nurse or BB – police officer.

Were practitioners sensitive to the needs of the adult at risk in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?
Did your agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare?
What were the relevant points or opportunities for risk assessment and decision making in this case in relation to the adult(s) at risk/or alleged perpetrator(s)? Do the assessments and decisions appear to have been reached in an informed and professional way?
Did action accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments?
Where relevant, were appropriate Safeguarding Adults Plan/risk assessments or care plans in place? Had review processes been complied with?
When, and in what way, were the adult(s)'s wishes and feelings ascertained and considered? Was this information recorded?
Was practice sensitive to any protected characteristics of the adult(s) at risk?
Were senior managers, or other agencies and professionals, involved at points where they should have been?
Was work in the case consistent with agency and SAB policy and procedures for protecting adults at risk and wider professional standards?
Please comment on any aspects of the case or the agency involvement that are examples of good practice.
Are there any particular features of this case, or the issues surrounding the case, that you consider require further comment in respect of your agency's involvement?
Are there lessons from this case for the way in which your agency works to protect adults at risk and promote their welfare?
Are there any aspects of SAB policy and procedures that need to be considered as a result of this review report?

Recommendations for action

Agencies should not wait until the completion of the Safeguarding Adults Review before carrying out any actions. These should be carried out as soon as possible.

(please add further rows to the table as required)

What action should be taken by your agency?	By whom	Timescale	What outcomes should these actions bring about?	How will the agency review whether they have been achieved?

Any other comments or information that you wish the Case Review Committee to consider?

Individuals involved in the case

Please identify the details of the professionals from within your agency who were involved with <Adult(s) X> and/or alleged perpetrators, and whether they were interviewed or not for the purposes of this Individual Management Review.

Designation/ role	Initials	Dates/ Period of Involvement	Type of involvement	Interview Yes/ no	Interview dates

List of all source documents you have used in completing your individual Management review

Document	Source: Paper or Electronic, Email / Fax, Interview tape	Date