



Newcastle Safeguarding Adults Review Policy and Procedure 2023

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Glossary of key acronyms

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

1. Introduction

The Care Act 2014 requires Safeguarding Adult Boards (SABs) to arrange Safeguarding Adults Reviews (SARs), mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

This is a joint North of Tyne policy which has been adopted by Newcastle and North Tyneside Safeguarding Adults Boards and Northumberland Children and Adults Safeguarding Partnership (hereon referred to as “the SABs”).

The Social Care Institute for Excellence (SCIE) [Safeguarding Adults Review Quality Markers](#) (2022) are a tool to support people involved in commissioning, conducting, and quality-assuring SARs to know what good looks like. This policy has been written with reference to the Quality Markers, and refers to the [North East SAR Quality Markers checklist and guidance](#) throughout. The Quality Markers are intended to be a guide to support good practice in conducting a SAR and do not need to be followed prescriptively.

A Safeguarding Adult Review is a multi-agency process that considers what lessons can be learnt. This includes highlighting areas of best practice which are shared with partners to enable the partnerships to improve services and prevent abuse and neglect in the future.

SARs are not used to apportion blame, and as such, will promote a culture that values professional expertise, shares responsibility, develops professional expertise and supports effective practice, strengthens accountability and creates a learning system.

SARs will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).

For the purposes of this Protocol an “adult at risk?” refers to someone aged 18 years and over that:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect, and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

This document sets out the criteria for conducting a SAR, and outlines methodology options for these learning reviews.

2. Policy

2.1 Purpose of a Safeguarding Adults Review

The overriding purpose of a Safeguarding Adult Review is to learn lessons and improve practice and inter-agency working.

The Care Act 2014 guidance outlines that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently, that may have prevented serious harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

The purpose of holding a Safeguarding Adult Review is to:

- establish the facts
- establish what lessons can be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of the adult) work together to safeguard and promote the welfare of adults
- review the effectiveness of procedures (both multi-agency and those of individual organisations)
- inform and improve local inter-agency practice and commissioning arrangements
- improve practice by acting on learning and developing best practice
- highlight good practice identified in the course of the review
- provide an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these.

2.2 Parallel Processes

<p>Refer to Quality Marker 8 guidance</p>	<p><u>Parallel processes:</u> Where there are parallel processes, the SAR is managed to avoid as much as possible; duplication of effort, prejudice to criminal trials, unnecessary delay, and confusion to all parties, including staff, the person and their family</p>
<p>NE QM Checklist</p> <ul style="list-style-type: none"> • Have you agreed the most appropriate process for the circumstances? • Can parallel processes be utilised for TOR's and scoping to avoid any duplication and repetition? • Is there defined agreed ownership of SAR documents? • Is there an index of SAR material and agreement on arrangements for disclosure? • Where necessary, are there early discussions with the police, CPS, coroner to consider any information relevant to criminal proceedings? 	

There are a number of processes which can run parallel to SAR's such as:

- Domestic Homicide Reviews (DHR's)
- Coroners Inquests
- Child Safeguarding Practice Reviews (SPR's)
- LeDeR Review (Learning from Lives and Death of people with learning disability and autistic people)
- Criminal investigations
- MAPPA Serious Case Review

For further information on these processes, see **Appendix A**.

In setting up a SAR the SAB should consider how the process can dovetail with any other relevant investigations or reviews that are running parallel, such as a child SPR or DHR, a

criminal investigation or an inquest. It will be essential to liaise with the Police Senior Investigating Officer where there are criminal proceedings ongoing, to consider disclosure issues, prevent interference with that process, and to ensure that relevant information can be shared without incurring significant delay in the review process.

It may be helpful when undertaking a SAR in parallel with other processes, to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. It will be the responsibility of the manager of the SAR to ensure contact is made with the lead partnership or agency to ensure there is effective co-ordination. Consideration should be given to establishing a joint Committee/Panel to oversee the relevant processes.

2.3 Criteria for conducting a Safeguarding Adults Review

The Care Act 2014 provides the legislative framework for Safeguarding Adults Reviews under Section 44.

SAB's **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) if:

- There is reasonable concern about how the SAB, partner agencies or other persons with relevant functions worked together to safeguard the adult AND
- The adult died as a result of abuse or neglect (or suspected abuse or neglect) OR
- The adult experienced serious abuse or neglect

The SAB **may** arrange a review of any other case involving an adult in the area with care and support needs where some of the criteria above are met, or where learning or good practice has been identified. This is sometimes referred to as a Discretionary Safeguarding Adults Review.

All members of the SAB (and other relevant agencies) must co-operate when carrying out reviews to ensure learning is identified and applied to future cases.

2.4 The relationship between Section 42 enquiries and Section 44 Safeguarding Adults Reviews

Section 42 enquiries are 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, and, as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. It is not a requirement to undertake a Section 42 enquiry before making a referral to the SAR Committee.

A Section 42 enquiry will always be required when there are potentially other adults at risk as 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 will be primarily concerned with safeguarding those adults who continue to receive a service from that organisation.

During the course of a Section 42 enquiry, it may be identified that the SAR criteria appears to be met. The decision around whether the SAR criteria have been met is for the SAR Committee and Independent Chair and not the Chair of the Safeguarding Adults Meeting/Safeguarding

Adults Manager coordinating a Section 42 enquiry. 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. The Section 42 enquiry will primarily relate to safeguarding individual(s) who are currently at risk, whereas the SAR process will consider a wider view of the way in which agencies have worked together.

3. Procedures

3.1 Identification and referral for a Safeguarding Adults Review

Refer to Quality Marker 1 guidance	Referral: The case is referred for consideration for a SAR with an appropriate rationale and in a timely manner.
NE QM Checklist: <ul style="list-style-type: none">• Does the referral explicitly identify how the SAR criteria has been met?• Does the referral specify the type of abuse or neglect suspected?• Have details of ethnicity and other protected characteristics relevant to the SAR referral been identified and appropriately recorded?• Does the referral specify clearly any other reason why a SAR is needed?• Does the information provided evidence the rationale given for why the case is being referred?• Does the referral specify required details in relation to: the type of abuse or neglect; ethnicity and other protected characteristics relevant to the SAR?• Are explanations provided for any delays in the referral?	

Any agency, professional, or individual may refer cases to the SAB. Referrals are to be made using the Consideration Request Form (see **Appendix B**) which is to be sent to the SAB area where the abuse or neglect occurred.

Newcastle	safeguardingboards@newcastle.gov.uk
North Tyneside	NTSAB@northtyneside.gov.uk
Northumberland	ncasp@northumberland.gov.uk

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

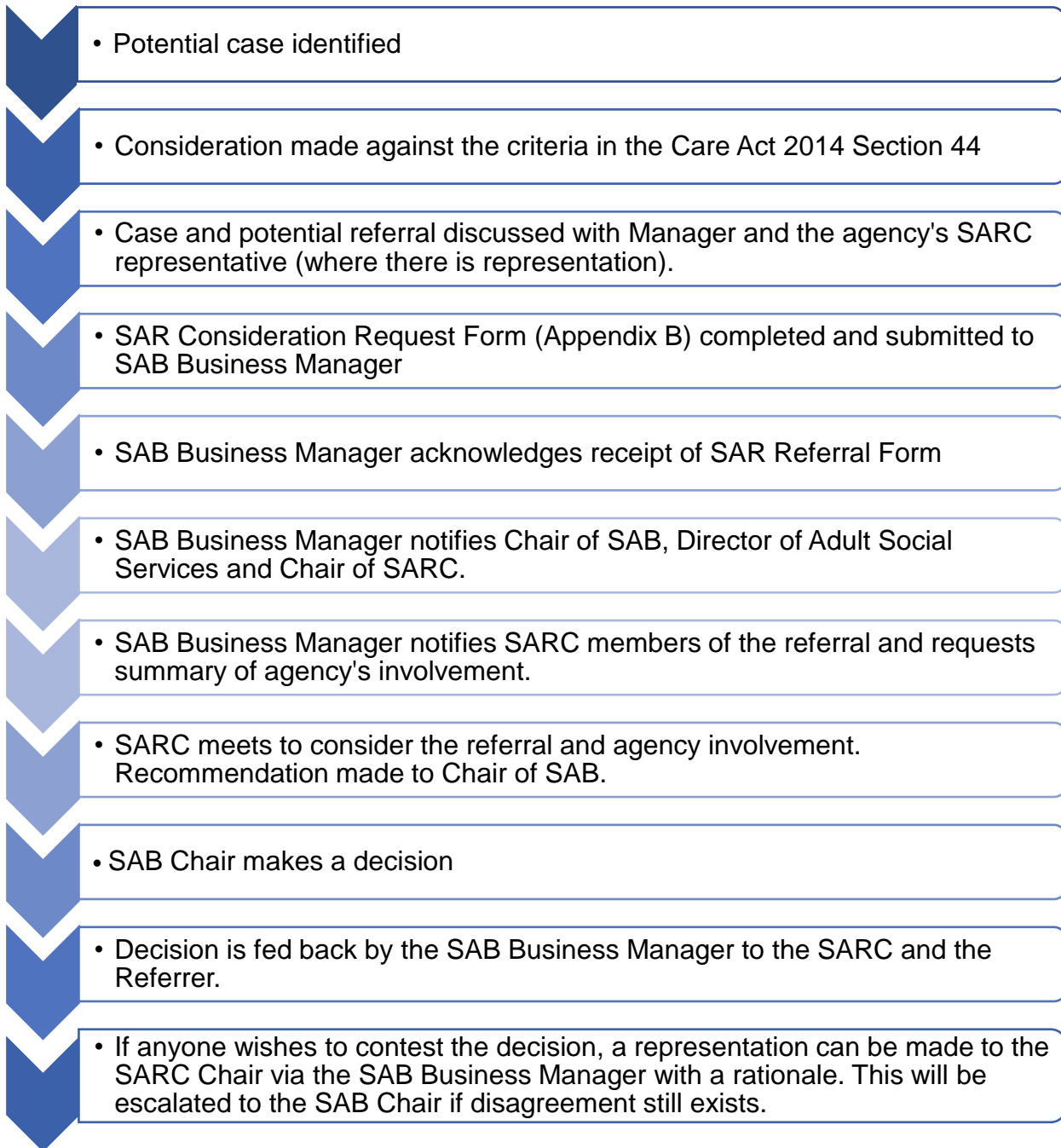
The Chair of the SAB and the Director of Adult Social Services (DASS) will be notified in the first instance.

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).

Agencies will be asked to complete an initial summary of their involvement using the template in **Appendix C**.

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.

3.2 SAR Referral Process



Note, if a referral is made by a family member/member of the public, steps 2 and 3 do not apply.

3.3 Decision Making

Refer to Quality Marker 2 guidance	Decision Making: What kind of SAR / Enquiry Factors related to the case AND the local context inform decision making about whether a SAR is needed and initial thinking about its size and scope
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NE QM Checklist:

- Is the rationale for the decision clear and defensible, paying close attention to the **Care Act 2014** and **Making Safeguarding Personal principles**?
- Is it evident how race, culture, ethnicity and other protected characteristics have been considered?
- Have all key agencies provided information about their involvement? (Consider other SAB areas)
- Has intelligence from other quality assurance and feedback sources been gathered e.g. audits/benchmarking, complaints and previous SARs? Has this been used to identify outstanding learning needs locally, as well as what is already known and does not need to be re-learnt?
- Have other review pathways been considered/discounted (e.g. DHRs), and have parallel processes been identified (e.g. complaints)?
- Have SAB member agencies had the opportunity to contribute to the decision-making process and recommendations to the Chair?
- Are the decision-making processes and outcomes transparent, and has independent challenge been considered?
- Is there transparency about any conflicts of interest and how they have been managed?
- Has legal advice been sought, if appropriate, to check the lawfulness of the decision making?
- Are explanations provided for any delays in decision making?

Refer to Quality Marker 4 guidance	Clarity of purpose: The Safeguarding Board / Partnership is clear and transparent from the outset that the SAR Process is statutory with the focus on learning and improvement across organisations and acknowledges any factors that complicate this
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NE QM Checklist:

- Have you communicated with all relevant parties (SAB members, involved agency/provider/commissioner leaders, practitioners, Legal advisors) about the statutory purpose of the SAR with a focus on learning and organisational development?
- Has there been a multi-agency discussion regarding any tensions and complications?
- Is the decision-making rationale clearly documented on all records?
- Is the escalation pathway clear, if there is any non-engagement by providers, commissioners or other agencies involved in the SAR?

The decision about whether to undertake 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 primary consideration for the SAR Committee is whether there is a statutory obligation to undertake a SAR, using the criteria in Section 2.3 above. 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. Any delays in decision-making should be referenced and explained.

The following table outlines the three main outcomes available to the SARC:

SAR	Other review/action	No action required
SAR criteria are met (or the SARC considers the circumstances warrant undertaking a SAR, sometimes referred to as a “Discretionary SAR”).	<ul style="list-style-type: none"> • Other review process (e.g. LEDER see Appendix A) • SARC co-ordinates learning review/event • Single-agency action • Assurance sought on issue/action 	The criteria are not met and no further action is to be taken

A SAR must be undertaken if there is a statutory requirement to do so. In cases other than those involving a statutory obligation, the SAR Committee should carefully consider whether commissioning or undertaking another type of review would be a valuable exercise: for example, whether an Appreciative Inquiry has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future.

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 and recommendation will be made in writing to the Chair of the SAB using the form in **Appendix B**. It may help inform the Chair of the SAB if minutes of the relevant SAR Committee are shared and a meeting is held between the Chair of the SAR Committee and Chair of the SAB to communicate the decision and rationale.

At this point, the Chair of the SAB has the opportunity to challenge and scrutinise the recommendation of the SAR Committee.

Following the SAB Chair’s approval, the decision will be shared with other SAB members (and the referrer if they are not represented on the SAB) at the next SAB and/or Executive meeting.

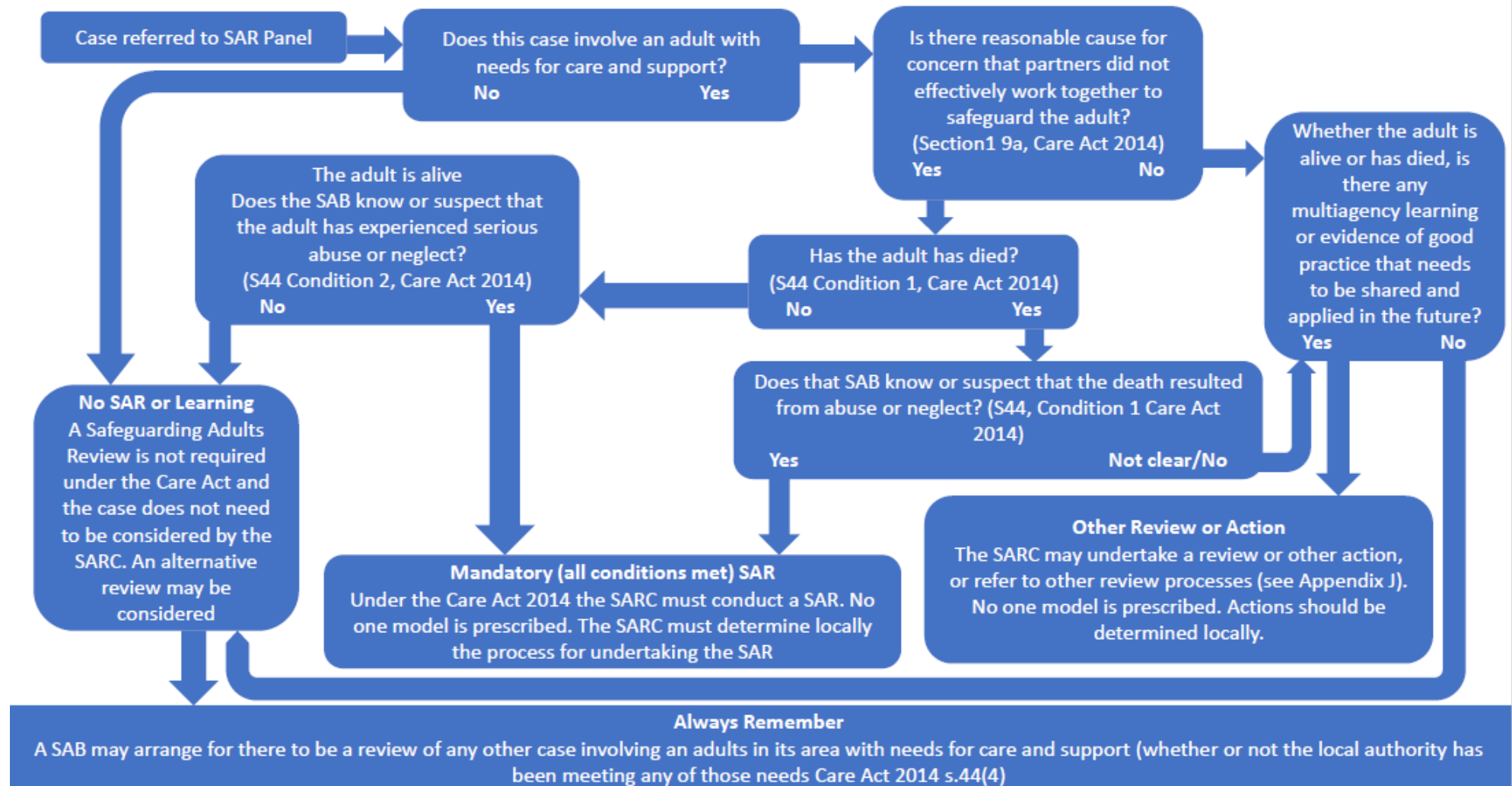
Should the referrer disagree with the decision made by the SAR Committee, this should be raised in writing with the Chair of the SAR Committee in the first instance. This will be escalated to the Chair of the SAB if disagreement still exists. Please refer to Section 3.15.

Whilst it should not influence the decision-making around whether the SAR criteria has been met, the SAR Committee will need to take into consideration at this stage any other relevant review processes (e.g. DHR, CSPR, LeDeR, Coroner) and ensure there is clarity around governance at the outset (refer back to Section 2.2).

The flowchart below, outlines the decision-making process.

3.4 Decision Making Flowchart

Safeguarding Adults Review – Decision Making Flowchart



3.5 Initiating a Safeguarding Adults Review

Refer to Quality Marker 5 guidance	Commissioning: Decisions about the precise form and focus of the commissioned SAR take into account a range of factors in order to make the learning and improvement proportionate. Decisions are made with input from the SAB Chair, members and reviewers.
NE QM Checklist: Have discussions about the form and focus of SAR to be commissioned considered the following: <ul style="list-style-type: none">• Is the approach to the SAR fit for purpose for the case and current context, and moves away from a one-size-fits all approach that assumes a set process and long report?• Has the scoping process covered all areas and issues covered by the SAR Quality Markers?• Have you agreed how learning from other SARs, as well as research evidence can be used to develop a proportionate approach to the SAR that builds on the evidence base about what good looks like, barriers and enablers, rather than starting afresh?• Has detail from any parallel processes or statutory reviews been utilized to avoid unnecessary duplication and agree joint commissioning where appropriate?• Have discussions about the precise form and focus of the SAR built on initial information gathering about case and local context, drawing on:<ul style="list-style-type: none">- Evidence of impact on adults with care and support needs and their families, including serious public concern and potential media interest- Other quality assurance and feedback sources e.g., audits/complaints- Relevance to SAB strategic and and/or current and future priorities- Previous SARs locally, regionally and nationally (as relevant).• Does the approach strike the right balance between methodological rigour and proportionate use of resources/capacity relative to the learning and impact expected?• Are there any issues regarding the capacity of practitioners, SAB and member agencies, and experienced/qualified reviewer(s)?• Does the process allow the reviewer(s) to influence the scope, nature and approach of the review?	

Once a decision has been made to conduct a SAR, the SARC should consider establishing a SAR Panel who will oversee the Safeguarding Adults Review. The Panel's role will be to quality assure the process and products (including agency contributions and the final overview report). Specific tasks that the Panel may undertake are:

- Appointing the Lead Reviewer
- Drafting and agreeing terms of reference (alongside the Lead Reviewer) and methodology for the SAR. An example terms of reference is included in **Appendix D**.
- Providing comments/feedback on draft SAR reports
- Agreeing a final draft SAR report before it goes to the SAB for approval
- Agreeing an action plan in response to the recommendations made.

The Panel is usually chaired by the Lead Reviewer and membership is made up of all agencies involved in the case and any specialist advisors that may support the SAR process (e.g. legal advisor, subject specialist).

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/Panel 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.

All review methodologies outlined have some degree of flexibility. **Appendix J** includes more information about different methodologies that may be used.

If the SAR criteria has been met, the Lead Reviewer must be independent of the agencies involved.

Where the SAB Chair concludes that a review is appropriate, the SAR Committee will need to coordinate the approach. 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? Template Individual Management Review and Chronology templates are included in **Appendices L and M**. Further guidance on IMRs is included in **Appendix K**.
- 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?

3.6 Timescales

Whichever approach is taken, once the Independent Lead Reviewer has been appointed, every effort should be made for the SAR to be completed within six months 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 review and/or due to ongoing criminal proceedings for example.

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.

3.7 Involvement of the person or their family

<p>Refer to Quality Marker 3 guidance</p>	<p><u>Informing the Person, their family and other important networks:</u> The person, relevant family members, friends and networks are told what the SAR is for, how it will work, the parameters, how they can be involved, and are treated with respect.</p>
<p>NE QM Checklist:</p> <ul style="list-style-type: none"> • Has the person, relevant family members, friends/network been informed of the SAR at the earliest opportunity? • Have the purpose, process and parameters of the SAR been communicated in the most appropriate way to promote understanding? • Have you agreed with the family their preferred methods and timeliness of communication throughout the process (verbal, written)? • Is there standard SAB correspondence available for use with family members in this SAR about the purpose, process and parameters of the SAR and is it adequately clear, accessible and kind? • Are opportunities being offered to discuss any queries about the SAR? 	
<p>Refer to Quality Marker 11 guidance</p>	<p><u>Involvement of the Person, family and relevant networks:</u> The SAR is informed by knowledge and experience of the person, family members and relevant social network, enabling the individual and family to see how the SAR is designed to have an impact and contribute to positive change.</p>
<p>NE QM Checklist:</p> <ul style="list-style-type: none"> • Is there a clearly documented and defensible decision process for involvement / non-involvement of the person / family with clarity around why they are involved, statutory requirements and the 6 Core Safeguarding Principles and of Making Safeguarding Personal? • Who will be the specific point of contact with the person / family and what are the arrangements to support them throughout the process? • Is there clarity about what the family will be asked? • How are the family to be represented in the final report and how do they provide feedback? 	

- Where there are criminal proceedings, has a discussion taken place with the police (Senior Investigating Officer) around the family involvement with the SAR Process?

SARs should reflect Making Safeguarding Personal principles¹. The SAR should be informed by the person or their family's, friends' (or other relevant network's) knowledge and experience relevant to the period under review. This may involve family contribution to the terms of reference of the review. The person and/or their representative(s) should be told the purpose of the SAR, 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 and/or their representative(s). Discussion should take place at an early stage with the adult and/or their representative to agree if and how they wish to be involved in the process, using the principles of Making Safeguarding Personal (MSP). If the adult and/or their representative(s) decline to participate in the SAR, they will be contacted once the SAR has been completed and advised of publication details.

There may be circumstances where the person or their family are informed at the point a SAR referral is being considered by the SAR sub-group. **Appendix P** can be used to support these discussions, and to provide further information about possible outcomes.

There may be circumstances when a decision is made to not involve the person and/or family members/friends or where there are no family members or friends known. There should be clearly documented decisions around involvement/non-involvement of the person or a representative.

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.

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

Under section 68 of the Care Act 2014, an independent advocate must be arranged 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.

The adult or their representative should be kept updated throughout the SAR process, as well as having the opportunity to contribute their views and experiences. It is best practice for the learning and recommendations to be shared with the adult and/or their representative(s) prior to publication of the SAR so that they have the opportunity to comment and provide their views.

¹ [Social Care Institute of Excellence, Making Safeguarding Personal Guide](#)

Consideration will need to be given to how best to provide the final SAR report to the adult and/or their representative(s) and when, in line with publication plans. At the end of the process, the adult and/or their representative(s) should be given the opportunity to provide feedback on their experience of the SAR process itself.

3.8 Practitioner involvement

Refer to Quality Marker 10 guidance	<u>Practitioner involvement:</u> The SAR is informed by the experiences and perspectives of practitioners and managers, enabling them to have a constructive experience of taking part in the review and cultivates an open learning culture.
NE QM Checklist: <ul style="list-style-type: none"> Does the SAR process express the value and importance of practitioner input and promote an open learning culture to all? Have the right practitioners and managers been identified to contribute to the process? Is the purpose of practitioner input clear and understood? Has an adequate Duty of Care to all participants involved in the SAR been secured and does the SAR planning make reference to this? How will you gather feedback from all those involved in relation to the process? 	

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

Practitioners and managers who were involved in the case are an important source of information for a 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.

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 F** for information which can be provided to practitioners about SARs.

3.9 The Report

Refer to Quality Marker 12 guidance	<u>Analysis:</u> The SAR analysis is transparent, assumes a systems approach and draws on the full range of relevant information to evaluate and explain professional practice. Conclusions are of practical value,
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and evidence wider learning around barriers and enablers to good practice.

NE QM Checklist:

- Are the Six Core Safeguarding Principles and Making Safeguarding Personal reflected in the evaluation of safeguarding practice of this case?
- Does the review take into consideration cultural, organisational and systems practice?
- Is current, up to date research evidence about good practice used in the analysis?
- Does the analysis have clear conclusions in relation this case and the wider safeguarding practice, including whether practice issues were unique to this case or a symptom of wider systemic issues?
- Are you promoting the value of identifying the range of learning (whether good or bad practice) that the case reveals?
- Is information from contributing agencies fully and fairly represented in the report?
- Does the SAB support analysis that seeks out causal factors and systems learning beyond the SAR / SAR's?

**Refer to Quality
Marker 13 guidance**

Report:

The report clearly and succinctly identifies the analysis and findings while keeping details of the person to a minimum. Findings should reflect causal factors, systems learning, single and multi-agency learning.

NE QM Checklist:

- Does the report meet the requirements of the commissioned specification?
- Is the tone and choice of words appropriate and is the report written in a way that is to the point, understandable and useful?
- Have the person / family had opportunity to comment and is there any legal advice required about publication?
- Does the report sufficiently protect the privacy of the person, family members and practitioners whilst still being accessible and able to support future practice improvement?
- Can the report be used to inform the work of the partnership to improve safeguarding outcomes and prevent future abuse and neglect?
- Does the report provide an insight into factors that increase the risk that people will not be effectively safeguarded or highlight areas that foster good practice?
- Does the report clearly identify and distinguish case findings from system findings?
- Is it clear that the Final Draft Report is confidential and not for distribution or public comment until the proposed publication date?

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.

As a minimum, the overview report should include:

- Overview of the case, including a summary of the circumstances that led to the SAR being undertaken.

- Outline of the methodology and SAR process, and the rationale for the chosen methodology(ies) and process?
- Details of how the adult(s)/family have been consulted/involved.
- Period under review.
- Reviewer independence.
- Demographic information. This should include reference to how race, culture, ethnicity and other protected characteristics outlined in the Equality Act 2010 may have impacted on the case.
- Analysis of events/circumstances, and subsequent findings.
- Clear, specific, and actionable multi-agency recommendations with clarity on the agencies to which they are directed and the timescales by when they should be completed.
- Identifying actions that agencies have already taken in response to learning.

The SAR Committee and Chair will agree the key learning points of the SAR that are included in the SAR Report. They will support the development of the report by reviewing draft versions and shaping the final recommendations. The SAR committee will agree the draft report before it is presented to the SAB, so that individuals are satisfied that the panel's analysis and conclusions have been fully and fairly represented.

The SAB must ensure that there is sufficient analysis, scrutiny and evaluation of evidence throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified should form the basis of any SAR report.

The adult(s) and/or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process.

3.10 Communication

Effective communications with relevant people and organisations are 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, Department of Health and Social Care).
- Elected Leads (Mayor, Leader of Council, Police and Crime Commissioner, Cabinet).
- Local Safeguarding Children Boards, Health & Well-being and Safer Community Partnerships, other Safeguarding Adults Boards.
- Health including **Hospital Trusts, ICB's, Specialist Trusts, Primary Care, Ambulance 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 H**). 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 have not been met, but it has been agreed that a review (of some type) will be undertaken, there is not a requirement to make the above formal notifications, apart from notification and liaison with the coroner. However, this will need to be something that the SAR Committee considers on a case-by-case basis.

3.11 Communications planning

<p>Refer to Quality Marker 14 guidance</p>	<p>Quality Marker 14: Publication and Dissemination The Board / Partnership should refer to statutory guidance to evidence the influence of decision to publish or not and take into consideration the risk to the individual's anonymity. Consideration should be given to the use of Executive Summaries and Learning Briefs.</p>
<p>NE QM Checklist:</p> <ul style="list-style-type: none"> • Is there a clear and effective Communication plan which secures the right level of engagement from senior leaders and include provision for any legal issues to be managed? • Can the Board / Partnership provide the rationale for the decision around publication/ non-publication of the Review and is this clearly documented? Does the plan clearly reflect the statutory functions and duties of the SAB? • Has the person/family member been fully involved in the decisions around publication and have their views have been considered and discussed? Have they been informed in advance of the report publication? • Does the communication plan engage with all the right audiences in an engaging and appropriate way? • Is there is a clear agreement in relation to content and timeframe for release, ensuring where appropriate, the anonymity of those involved? • Are there any other issues that would prevent publication of the full report? (community tensions, criminal proceedings, media interest) • Does the publication date clash with any other important dates or activities (anniversaries, criminal trials, media interest)? • Has the SAR Regional Learning Template been completed for the case to be recorded in the Regional SAR Library? 	

The respective Local Authority Communications team will take the lead in guiding the 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 3.7 above
Practitioners	<p>See section 3.8 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:</p> <ul style="list-style-type: none"> • Update of learning and development programmes to reflect the findings of the SAR. • Publication of short summaries/leaflets/7-minute briefings with a practitioner focus. • Offering bespoke briefings about the SAR. <p>The above may be single or multi-agency.</p>
Public	<p>The SAB will:</p> <ul style="list-style-type: none"> • 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).² An anonymised report will be published unless there are exceptional circumstances not to do so. In such an event, an Executive Summary may be made available. • Publish an additional statement from the Independent Chair which sets out the recommendations of the SAR, factual information and that 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	<p>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.</p> <p>To facilitate this, the SAB will ensure that communications leads for member organisations are kept up to date on forthcoming reviews. This will be co-ordinated through the respective Local Authority Communications team.</p>

² It is best practice for SABs to publish SAR reports but not a duty to do so. Paragraph 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."

	<p>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:</p> <ul style="list-style-type: none"> • 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).
<p>SAB Members</p>	<p>All members of the SAB will be kept informed regularly throughout the SAR process.</p> <p>This will be achieved by:</p> <ul style="list-style-type: none"> • Agreeing a 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. <p>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.</p> <p>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.</p> <p>Representatives of member organisations of the SAB will be responsible for providing regular feedback on the SAR process, within their own organisations as appropriate.</p>

3.12 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, and where applicable, the Coroner. See **Appendix I** for example covering letter.

Publication:

There is a statutory duty to publish the findings of SARs (paragraph a(1)(d)-(g), Schedule 2 Care Act 2014), however the method and extent of publication is determined by the SAB.

SAR Report publication may be affected by other parallel processes such as criminal proceedings/court cases, alongside data sensitivity issues of the subject(s) of the review. Whilst publication of the report may be delayed, the lessons learnt and recommendations can be taken forward once the SAB Members have agreed the report.

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 must be included within the SAB’s Annual Report for that year.

Once published, consideration should be given to adding the SAR to local and national repositories where available.

3.13 Implementation of the learning

<p>Refer to Quality Marker 15 guidance</p>	<p>Implementation Action and Evaluation of Impact Evaluation of impact is designed from the start with systemic improvement actions agreed across all partners. Any actions should be aligned with wider strategic improvement activity and led locally, regionally or nationally. The SAB retains a record of findings and actions.</p>
<p>NE QM Checklist:</p> <ul style="list-style-type: none"> • Has the Board / Partnership actioned the findings and recommendations and evaluated the impact? • Have the SAR findings been communicated and embedded in multi-agency training and guidance? • Does the Board / Partnership utilise performance data to evidence and evaluate the impact of learning? • Has any good practice been highlighted and shared? • Has the learning been shared locally, regionally and where appropriate escalated nationally? • Has any regional learning been identified through the Northeast SAR Library and if so how will this be progressed? • Where learning has been identified previously – is there a clear strategy to embed and revisit this learning? 	

- Is there a process to revisit the learning, and seek assurance this has been embedded in practice at future intervals?

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.

Any recommendations MUST be SMART (specific, measurable, achievable, result-oriented and time-bound). A template action plan is included at **Appendix M**.

For recommendations arising from Individual Management Reviews (IMR) or from Single Agency Reviews, it will be the responsibility of that agency to oversee and implement any actions identified and report back to the SAR committee, who will ensure any barriers or delays are addressed.

It is the responsibility of SAB members to ensure learning and service change from any safeguarding review is understood, embedded and evidenced within their organisation. SAB members will be held accountable for these actions at board meetings. Any actions relating to areas of work within the remit of SAB subgroups will be passed to them to progress. These actions are owned by the relevant subgroup chair who will be expected to submit regular updates to the SAR committee.

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. Progress against the action plan, and exception reporting will be made to the SAR committee at least quarterly.

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.

There is a national escalation process³ to raise issues arising from a local SAR which requires a national response. This involves:

- Stage 1: Discussion at Regional SAB Chairs' Network
- Stage 2: Discussion at National SAB Chairs' Network
- Stage 3: Contact with DHSC policy leads and others
- Stage 4: Feedback to National SAB Chairs' Network

The SAR committee will need to consider how the impact of learning will be evaluated to ensure it has been embedded in practice.

³ [National Escalation Process for SARs](#)

At the end of the SAR process the SAR committee should evaluate the whole process, to inform the future commissioning and coordination of SARs.

3.14 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. Any variations will need to be carefully considered by the SAB and Chair, in terms of identifying the subject, but also implications for any associated children or family members.

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 2018 (implementing the General Data Protection Regulations).

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 advisor 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 the SAR will be retained by the SAB for a minimum of 20 years following the publication of the SAR. This takes into account that the information might: be required to protect other adults at risk; need to be accessed by the data subject at a later date; or be subject to future investigations, inquiries and litigation⁴. 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. 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.

⁴ In the absence of legislation or regulation, the designated retention period has been informed by the [Health and Social Care Records Retention Schedule](#) which states that “The retention periods listed in this retention schedule must always be considered the minimum period. With justification, a retention period can be extended for the majority of cases, up to 20 years” AND the R v Northumberland County Council and the Information Commissioner (23 July 2015) judgement which provided assurance that it is legitimate to vary common practice and guidance where there is a well-reasoned case for doing so.

3.15 Complaints

It is acknowledged that complaints may occur at any stage in the SAR process. This may relate to the decision about whether a SAR should be commissioned, how it is commissioned, and any aspect of the outcome of the review, including the content of the report. A dispute may arise because of a disagreement or complaint from anyone involved in the SAR process, including family members.

The SAB retains ultimate responsibility for the SAR process, therefore where a dispute arises, it should be dealt with as follows:

- In the first instance, those responsible for the relevant part of the SAR process should attempt to resolve the dispute, for example the SAR committee and/or report author during the undertaking of the review.
- If the dispute cannot be resolved, the SAB Manager, following consultation with the SAB Independent Chair, will initially respond with a written response within 28 days of receipt.
- If the complainant is dissatisfied with the response, they should contact the SAB Manager who will arrange for their complaint to be considered by the SAB Independent Chair. The SAB Independent Chair will provide a further written response within 28 days of the complainant contacting the SAB Manager.
- All written complaint responses will include details of how to contact the Local Government Ombudsman.
- The SAB 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.

Escalation:

It should be noted that Local Authorities have overall responsibility for SABs and ensuring there are appropriate multi-agency policies in place. Therefore, if a dispute cannot be resolved via above, a complaint can be made to the Local Authority. As SABs are an administrative function of the LA, if required, complaints can be escalated to the Local Government Ombudsman (LGO)⁵.

Ultimately decision-making can be challenged in the High Court by way of judicial review or investigated by the Local Government and Social Care Ombudsman. This applies to Safeguarding Adult Review processes.

⁵<https://www.adass.org.uk/media/4104/cpf-26-150203-safeguarding-adults-boards.pdf>

Appendix A

Overview of different types of Learning Reviews

Effective liaison is required between the relevant multi-agency strategic partnerships (e.g. child safeguarding, adult safeguarding, community safety) or lead agencies to determine the most appropriate review process that maximises learning, minimises duplication of effort and reduces anxiety for families involved.

Title of Review	Domestic Homicide Review
Lead partnership/ agency	Commissioned and coordinated by Community Safety Partnerships and overseen by the Home Office
Overview and purpose	Statutory, multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.
Title of Review	Safeguarding Adults Review
Lead partnership/ agency	Commissioned and coordinated by Safeguarding Adults Boards
Overview and purpose	Statutory, multi-agency review where an adult (aged over 18) with care and support needs has died or experienced serious abuse/neglect and there is reasonable cause for concern about how the Safeguarding Adults Board, members of it, or others worked together to safeguard the adult.
Title of Review	Child Safeguarding Practice Review
Lead partnership/ agency	Safeguarding Children Partnership
Overview and purpose	Statutory, multi-agency reviews where abuse of a child is known or suspected and the child has died or been seriously harmed (referred to as a serious child safeguarding case). A multi-agency rapid review will be undertaken initially to determine whether a Child Safeguarding Practice Review is required.
Title of Review	Child Death Review
Lead partnership/ agency	Local Authorities and Integrated Care Boards
Overview and purpose	A child death review must be carried out for all children regardless of the cause of death. The purpose of a Child Death Review is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety.

Title of Review	Multi-Agency Public Protection Arrangements (MAPPA) Serious Case Review
Lead partnership/ agency	MAPPA Strategic Management Board
Overview and purpose	Undertaken when an offender subject to MAPPA commits a Serious Further Offence (SFO). The purpose is to examine whether the MAPP arrangements were effectively applied and whether agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.
Title of Review	LeDeR Reviews (Learning from lives and deaths – people with a learning disability and autistic people)
Lead partnership/ agency	Integrated Care Boards
Overview and purpose	LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review, however the primary review process for children is the Child Death Review process.
Title of Review	Coroner's Inquest
Lead partnership/ agency	HM Coroner
Overview and purpose	<p>A Coroner must hold an inquest if there is reasonable cause to suspect that the death was due to anything other than natural causes. An inquest must also be held when a person has died whilst in state detention (e.g. prison/police custody).</p> <p>An Inquest is an investigation into a death which appears to be due to unknown, violent or unnatural causes, designed to find out who the deceased was, and where, when and how (meaning by what means the person died). At the end of the Inquest, the Coroner will give his/her conclusion about the cause of death. The Coroner can write a report in cases where the evidence suggests that further avoidable deaths could occur and that, in the Coroner's opinion, preventative action should be taken. The report will be sent to the person or authority which may have the power to take the appropriate steps to reduce the risk and they have a mandatory duty to reply within 56 days.</p>

Title of Review	Offensive Weapon Homicide Review
Lead partnership/ agency	Police, Local Authorities, Integrated Care Boards (Partnership TBC, likely to be Community Safety Partnerships)
Overview and purpose	Reviews into homicides where the victim is aged 18 or over, and the events surrounding their death involved, or were likely to have involved the use of an offensive weapon. The purpose of the review is to identify the lessons to be learnt from the death, to consider whether any action should be taken as a result, and to share the outcome. Local and national implementation of these lessons and any such actions are intended to help tackle homicide and serious violence.

Appendix B



Consideration Request Form for a Safeguarding Adults Review

- Part A – Referral
- Part B - SARC consideration and decision
- Part C - SAB Independent Chair Review

PART A – Referral

Please complete as fully as possible after discussion with your agency’s SAB representative who will submit to the SARC chair. If your agency does not have a SAB representative please discuss with the [SAB Coordinator](#).

Referrer Details	
Name	
Job Title	
Organisation	
Contact details	

Date of Referral	
Please detail any reasons for a delay in referral	

Details of Adult	
Name	
Address	
Date of birth	
Date of death (if applicable)	
Ethnicity	
Any protected characteristics which should be taken into account.	
Was the adult a care leaver or care experienced?	Yes/No/Unknown Specify details where known:
Name and address of GP	
Family/ Next of Kin/ Advocate	
Was/is the adult known to any other agencies that you’re aware of?	Yes/No/Unknown Specify any known agency involvement:

Circumstances of the case	
Brief details of case	<i>(include chronology of events, details of allegation of abuse or neglect, agency responses, key decisions made, any safeguarding adults procedure followed)</i>
Type of abuse/neglect suspected in death/serious harm	Physical/Sexual/Emotional/Neglect/Financial/Organisational/Domestic Abuse/Self-Neglect/Discriminatory/Modern Slavery/Criminal Exploitation
Any other relevant information	

Parallel processes	
Is this incident the subject of any concurrent internal investigation? E.g. Serious Incident, Disciplinary, Complaint.	Yes/No Specify:
Is this incident the subject of any concurrent external investigation or legal process? E.g. Inquest, LeDeR, Police investigation	Yes/No Specify:
Has a safeguarding concern been raised in relation to the incident/s which resulted in the death or serious harm?	Yes/No Local Authority: Date concern raised:

Rationale for Safeguarding Adults Review referral	
Does the individual have Care and Support needs? Please provide details:	
Did they die or suffer significant harm? AND is there a suspicion that abuse or neglect contributed to the death or harm? Please provide details.	
Is there a reasonable cause for concern about how agencies worked together to safeguard the adult? Please provide details:	
Why, in your opinion, should this case be considered for a Safeguarding Adult Review?	
Is the case known to the Coroner? Has the Coroner been notified of the SAR consideration?	Yes/No/Unknown

Email the completed referral to the [NSAB Coordinator](#).

PART B – SARC consideration and decision

Date of Meeting	
Agencies Present	
Information Reviewed	
Summary of Discussion	
<p>Recommendation</p> <p>Is a SAR proposed?</p> <p>If not, is an alternative review type recommended?</p>	<p><i>In making the recommendation, the SAR Committee should primarily be concerned with whether the Section 44 Care Act 2014 criteria has been met. SAB's 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) if:</i></p> <ul style="list-style-type: none"> • <i>There is reasonable concern about how the SAB, partner agencies or other persons with relevant functions worked together to safeguard the adult AND</i> • <i>The adult died as a result of abuse or neglect (or suspected abuse or neglect) OR</i> • <i>The adult experienced serious abuse or neglect</i> <p><i>Discussion points which the SAR Committee may find helpful to consider:</i></p> <ul style="list-style-type: none"> • <i>Were there risks to the adult which were not recognised and acted upon appropriately by an organisation or individuals in contact with the adult or perpetrator?</i> • <i>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?</i> • <i>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?</i>

	<ul style="list-style-type: none"> • <i>Was the adult open to safeguarding or had they previously been subject to safeguarding arrangements?</i> • <i>Does the case appear to have implications for a range of agencies and/or professionals?</i> • <i>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 understood or acted on?</i> • <i>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?</i>
Is notification to HM Coroner required? Notification will be required before the commencement of a SAR or any other type of review.	
Further Actions	

Name (SARC Chair)	
Date	
Signature	

PART C – SAB Independent Chair Review

I endorse the recommendation for a SAR to be undertaken	
I endorse the recommendation for a SAR not to be undertaken	
Further information/ clarification is required (refer back to SARC)	
Comments	

Name (SAB Chair)	
Date	
Signature	

Appendix C

Safeguarding Adults Review – Agency Involvement Form

XX SAB have received a SAR referral and need to gather information to help make a decision about whether the criteria for a SAR has been met.

We require a return of the below information no later than xxxx. Please return to xxxxx

1. Identifying details

Adult Subject(s)	Address	DOB
This section is pre-populated before sending	This section is pre-populated before sending	This section is pre-populated before sending

Relevant family members:	Address	DOB
This section is pre-populated before sending	This section is pre-populated before sending	This section is pre-populated before sending

2. Brief outline of case

This section is pre-populated before sending

3. Person and agency completing this form (please include contact details)

Name of person completing this form			
Role		Agency	
Email address			

4. Summary chronology of agency involvement

Please detail key contacts and summary of involvement from xxxxxx to xxxxxx – **a full chronology is not required** at this stage. Please note the following key information:

- Significant events, attendance at appointments;
- Involvement of other agencies/friends/family (with contact info where possible);
- Changes in level of need/engagement with agencies and
- Referrals of concerns, and how these were received by other agencies.

Date (dd/mm/yyyy)	Contact

Please detail any relevant information outside of the timeframe here

--

5. Brief analysis of individual or / and agency practice.

Please comment on where you believe there may be opportunities for learning for your organisation and any good practice you have identified.

--

6. Multi-agency working

Please identify any areas for concern as to the way in which partners have worked together to safeguard the adult. Does this case highlight any recurrent themes in the safeguarding and promotion of the welfare of adults?

--

Please list the other agencies, departments or services that your records show had contact with the subject(s) of the review. *This information is vital for us to be confident that we have a clear picture of multi-agency working.*

--

7. Any other relevant information or comments

--

Appendix D

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.

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 a Safeguarding Adults Review is not to reinvestigate or to apportion blame, undertake HR duties or establish how someone died. Its purposes are:

- 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 shared and acted upon?
- When, and in what way, were Adult X or their 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, and did it consider the impact of, 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 (the 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 Reviews. 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.

Safeguarding Adults Review – Information for families and carers

Introduction

- When an adult who needs care and support dies and abuse or neglect is thought to have been a factor, the *Insert Board name* Safeguarding Adults Board may need to review what has happened. This is called a Safeguarding Adults Review or SAR. SABs must also arrange a SAR when an adult with care and support needs has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.
- These reviews are undertaken to find out if any lessons can be learned about the way organisations have worked to support and protect the person who suffered harm.
- We understand this is likely to be a very difficult time for family and we want to learn as much as possible about how to do things better in the future.
- We would welcome family involvement in the process as much as possible. We believe families, friends and carers should be able to discuss any concerns they may have and to share their thoughts and opinions.
- This information tells you about what happens when a Review needs to happen and what you should expect.

What is the *Insert Board name* Safeguarding Adults Board?

- The *Insert Board name* Safeguarding Adults Board brings together all the main organisations who work with adults who have care and support needs who may be unable to protect themselves from abuse or neglect as a result of those needs – this is called an ‘adult at risk’. The Board works together to help and safeguard adults at risk from abuse or neglect.

What is a Safeguarding Adults Review?

- The purpose of a Safeguarding Adult Review is to find out how organisations, agencies and professionals work together to keep adults, who need care and support, safe from abuse or neglect. It also aims to prevent what happened from happening to others.
- A Review will try to ensure that organisations providing public services like Councils, Health services, Police and other organisations understand what happened and identify where responses to the situation could be improved.
- 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 keep adults with care and support needs safe from abuse or neglect in the future.
- Safeguarding Adult Reviews are part of the Care Act 2014 and became law from 1st April 2015.
- The review is completely separate from any investigation being undertaken by the Police and/or Coroner and it concentrates on the work of the professionals, organisations and agencies who have been involved with your family.

How will we undertake the review?

- The review will be overseen by a panel formed of members from local statutory and voluntary bodies which may include Adult Social Care, Health Services, the Police and sometimes other organisations. The panel will not include any individuals who have been directly involved with the adult.
- The Safeguarding Adults Board will also appoint an Independent Report writer (or author) with the appropriate skills and experience, and who will be independent of any of the organisations involved in the Review.
- This Report writer will gather information from those organisations who worked with the adult, and other people who were important to the person, including family members, friends, or carers. This is to identify whether any lessons can be learned about the way agencies and organisations work together to safeguard adults at risk.
- They will produce a final report with recommendations on how to improve future practice.
- When the Review has been completed agencies and organisations will then consider what actions they may need to take to change the way they support adults at risk and their families.

How long will the Safeguarding Adult Review take?

- The Safeguarding Adults Review is usually completed within 6 months of the original referral. However sometimes they can take much longer, because of the complexity of the situation, and other related investigations, enquiries or court proceedings.

Your involvement in the review

- Family, friends and carers can be the best people to help us understand what happened. Your contribution will be valuable and may help change the way organisations respond to keeping adults with care and support need safe from abuse or neglect.
- We understand this will have been a very difficult time for you and we do not want to add to your distress, but it is important we inform you the review is taking place and give you an opportunity to be involved.
- If you do decide to take part in the review, we will ask you to share your understanding of what happened and why. You can give your thoughts and views in a face-to-face meeting, via a telephone conversation or in writing.
- The information you share will help us to build a fuller picture of what happened and in turn will help us identify recommendations for change.
- An Independent Advocate will be provided to an adult who needs assistance with the process but does not have anyone to assist them.
- If family members choose not to take part in the Review, we will still ensure they are kept fully informed of the outcome.
- The decision to take part in this SAR is entirely yours and if you do not wish to take part your decision will be respected. If you decide not to take part, we will contact you again to let you know when the SAR has been completed and if the report is going to be published.

What will happen to the information you share?

- The information you share will help us to build a comprehensive picture of what happened and will help us identify recommendations for change. These recommendations will then be put into an action plan.
- Your contribution will be confidential, and you will not be named in the final report.

Outcome of the Safeguarding Adults Review

- A final overview report will be produced which will identify what lessons have been learned and make recommendations for the Safeguarding Adults Board. An action plan will be produced as a result.
- The Safeguarding Adults Board will approve the final version of the report, which will be shared with family.

Publication of the Safeguarding Adults Review

- The final overview report will normally be published on the *Insert Board details/website link website*. The report will be fully anonymised and will not contain any identifying details. It will be available to all professionals to ensure that the lessons learned and recommendations are put into practice. However where there is highly sensitive information, a redacted summary may be created for publication.

Further information and support

If you require any support or information regarding the Review. Please contact:

Insert contact details of Board Manager or alternative point of contact

Appendix F

Safeguarding Adults Review – Information for Professionals

What are Safeguarding Adults Reviews?

A Safeguarding Adults Review (SAR) is a statutory review of how individuals and agencies worked together to safeguard an adult (or adults) at risk. Safeguarding Adults Boards have a legal duty under the Care Act 2014 to undertake a review where an adult at risk has died as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult(s). A SAR must be undertaken if the adult at risk is still alive, but they experienced serious abuse and neglect and there are concerns about how agencies worked together to safeguard the adult(s).

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. Safeguarding Adults Reviews are an important part of learning and improving, both on a single, and multi-agency basis.

Who will undertake the review?

SABs can choose to undertake SARs using different methodologies, but they are usually led by an independent person(s) who did not have any involvement in the case. The Lead Reviewer(s) is appointed by a SAR Panel made up of senior managers from the organisations involved. The agencies involved might be asked to complete an Individual Management Review (IMR) as part of the SAR process. IMRs are usually authored by a member of staff who did not have any involvement in the case, including line management responsibilities.

Your involvement in the review

Practitioner views and experiences are a crucial part of the review process. You will be asked about your involvement and questions will include things that you think worked well, as well as things that might need to change.

Who will speak to you will depend upon the approach taken to review the case. It could be a manager from your agency who is writing the individual management review (IMR) report, or it could be someone independent of your organisation, or both. It is quite common for reviews to include practitioner events that help to inform findings and recommendations.

You might be asked to expand on information contained in files or to clarify what you have recorded.

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.

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

Whilst those involved in reviewing the case have a duty to report any concerns (with relevant managers within agencies) about practice that might put adults or children at risk, it is not the role of Safeguarding Adult Reviews to apportion blame.

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 of it starting. It could be longer depending on the outcomes of other inquiries, for example, any ongoing criminal proceedings against the perpetrator(s).

What does the review produce?

A detailed, anonymised, report and summary of that report is produced. This will be available on a public website.

An action plan is produced to ensure any recommendations made in the report are taken forward appropriately. Progress against this action plan is monitored by the Safeguarding Adults Board.

Confidentiality

SAR's are confidential and details of the case should not be shared with people who are not connected to it.

Support

Safeguarding Adults Reviews are a supportive process designed to reflect on a case and identify learning. If you are asked to be a part of the review, then support and information will be available through your line manager.

Your agency representative on the SAR Panel is responsible for keeping staff informed, where appropriate and relevant, of what is taking place in the Review process.

Your line manager should also have relevant information about the review and will assist and support you as required. Staff are encouraged to raise any worries or concerns that they may have with their manager so that appropriate support can be provided. 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.

Appendix G

Letter to notify CX/Equivalents of intention to undertake SAR

FAO: Chief Executive Officer or equivalent

Re: Notification of Safeguarding Adults Review

I am writing to inform you that the **<insert name of Safeguarding Adults Board>** Safeguarding Adults Review Committee have considered a referral for a Safeguarding Adults Review (SAR):

Subject of Safeguarding Adults Review:

Address:

Date of Birth:

SARs are a legal requirement under the Care Act 2014 when:

- An adult with care and support needs has died and it is known or suspected that the death resulted from abuse or neglect; OR
- An adult with care and support needs has experienced serious abuse and neglect;
AND
- There is reasonable cause for concern about how the SAB or members of it (or other persons with relevant functions) worked together to safeguard the adult.

Each member of the **<insert name of Safeguarding Adults Board>** must cooperate in and contribute to the SAR with a view to identifying lessons to be learnt from the case and applying those lessons to future cases.

Please ensure that all written and electronic records held by your organisation for the above-named person are made secure.

The SAR process will be overseen and quality assured by the **<insert name of Safeguarding Adults Board>** Safeguarding Adults Review Committee. A list of current SAR Committee members is included with this letter for your information. It is anticipated that the SAR will take at least six months to complete. A copy of the final **SAR report/executive summary** will be sent to you on completion.

A full account of the **<insert name of Safeguarding Adults Board>** Safeguarding Adult Review process can be found here: **<insert link for SAR policy and procedures>**.

Thank you for your co-operation.

Yours sincerely

Chair, **<insert name of Safeguarding Adults Board>** SAR Committee

ENC. List of SAR Committee Members

Appendix H

Letter to notify Coroner of intention to undertake SAR/Other Review

Note: If the SAR Committee decides the SAR criteria are not met but another type of review is to be undertaken, it is best practice to notify the Coroner in a similar manner as below.

Dear HM Coroner,

Re: Notification of Safeguarding Adults Reviews/Learning Review

The <insert name of SAB> Safeguarding Adults Review Committee considered the following case to decide whether it met the criteria to initiate a statutory Safeguarding Adults Review. The Committee concluded that this case met the criteria to commence a Safeguarding Adults Review.

Subject of Safeguarding Adults Review:

Address:

Date of Birth:

Please could you confirm whether there is to be an Inquest or any other investigation pending by the Coroner which may need to be taken into account by the Safeguarding Adults Review Committee when planning the Safeguarding Adults Review?

If you have any queries or concerns in relation to this case, please do not hesitate to contact <insert name and contact details of relevant person>.

Yours faithfully

Chair, <insert name of Safeguarding Adults Board> SAR Committee

Appendix I

Letter to notify conclusion of SAR

Dear Colleague,

Re: Notification of Safeguarding Adults Review Conclusion

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

Subject of Safeguarding Adults Review:

Address:

Date of Birth:

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 <insert Safeguarding Adults Board name> would like to thank you for your agency's co-operation with this review and subsequent support with taking forward actions.

Yours faithfully

Chair, <insert name of Safeguarding Adults Board> SAR Committee

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. The SAR Committee/Panel will need to consider the various options and decide which approach is likely to provide the most learning. The SAR Committee/Panel should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious abuse or neglect occurring again. It might involve using a hybrid of some of the methods below. The methodology should be proportionate to the presenting circumstances.

Reviews involving the submission of agency chronologies and/or Individual Management Reviews

This is a well-known and long-standing approach to undertaking reviews. It involves the agencies involved with the case completing chronologies and/or Individual Management Reviews (IMRs). Agency authors need to research case files and speak to the staff involved and produce a report analysing their involvement. There is further information about this process included in **Appendices K-M**.

Practitioner Workshops/Learning Event

Practitioners should be involved in Safeguarding Adults Reviews and a Practitioner Workshop/Learning Event is a good way of hearing from the practitioners about their involvement. They are usually led by the SAR author and enables the reviewer to understand in greater depth whether there are any lessons that can be learnt to improve practice in the future and it also enables good practice to be identified and shared. Research in Practice have guidance on [Developing Effective SAR Learning Events](#).

Learning Together review

This is a systems-based approach (a model that identifies the factors in a work environment that support good practice, and those factors which create unsafe conditions in which poor safeguarding practice is more likely) to reviewing a case. The central idea of the systems approach is that any worker's performance is a result of both their own skill and knowledge and the organisational setting in which they are working. [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)).

Appreciative Inquiry

The Appreciative Inquiry approach asks open questions about what worked well, alongside what might and should be different in the future. The approach recognises that in order for people to be able to think, reflect, learn and change; participants need to feel supported, respected and valued. Appreciative Inquiry tries to place more emphasis on learning from good practice through "conversations". Usually, the case is reviewed at one event involving the practitioners that were involved with the case. The "5D" process is one of the core Appreciative Inquiry tools and is useful way of designing an Appreciative Inquiry agenda:

1. Definition – what is the inquiry?
2. Discovery – what worked/is working well?
3. Dream – imagining what could be.
4. Design – determining what should be.
5. Destiny/Delivery – creating what will be (an action plan).

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.

As with the Learning Together approach (see above), SILP is a whole systems approach which: directly hears the voice of frontline practitioners involved in critical events; examines how their interaction with different workplace systems affects understanding, decision-making and action; and explores how these different systems interact across agency boundaries. Each review is 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.

SARs in Rapid Time

This is a [SCIE developed model](#) which undertakes SARs in rapid time. A SAR In Rapid Time aims to have a turnaround time of 15 working days from set-up meeting, held after the decision has been made to progress with a review. An outline of the process is:

Schedule	Process
Day 1	Set up meeting
Days 2–7	Check agency records
Days 8–11	Produce early analysis report to structure discussion
Days 11–12	Participants read report in preparation
Day 13	Structured multi-agency discussion
Days 14–15	Systems finding report

Standardised processes and templates support this speedy turnaround. SCIE can independently facilitate the approach or the templates and tools can be used by anyone who would like to use the model.

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.

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, 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 who will read, amend and ultimately sign-off 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 who will

sign-off the IMR report on behalf of the organisation, before it is forwarded to the SAB Coordinator/Manager by the deadline specified, who will arrange for it to be forwarded to the Lead Reviewer. The **Authorising 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 SAB Coordinator/Manager 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 agency's senior manager.

Appendix L

IMR Template

Safeguarding Adults Review: Individual Management Review

Name of subject	
Address of subject	
Date of birth of subject	
Date of death of subject (if applicable)	

Name of person completing IMR	
Role and organisation	
IMR signed off by	
Date:	

This IMR is produced as part of the Safeguarding Adults Review. It provides an opportunity for each agency to identify the services that they offered to <Adult X>. The report author should provide a summary of the case from their agency perspective and provide an analysis of practice.

Agency involvement and analysis

<p>Factual/contextual summary</p> <p>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>.</p>
<p>Chronology of agency involvement</p> <p>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.</p> <p>Names of staff members should not be used but use anonymised initials and job roles eg AA – nurse or BB – police officer.</p>
<p>Addressing the key lines of enquiry/terms of reference questions</p> <p>Add in here the agreed key lines of enquiry/terms of reference questions. E.g.</p> <p>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?</p>
<p>Did your agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare?</p>
<p>Etc, adding further rows to the table as required.</p>

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 to be considered in respect of this case?

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
	Anonymised				

Appendix M

Safeguarding Adults Review: Agency Chronology of Involvement

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

Note: Agencies should maintain a key of any anonymised initials/references

(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 N

SAFEGUARDING ADULTS REVIEW ACTION PLAN "NAME OF SAR"

Case Description	Summary of case
-------------------------	-----------------

RAG Rating Index	Red	Major problems and issues threatening the action, behind schedule and not expected to recover. Requires intervention from SAB
	Amber	Some problems and or delays with the action but expected to recover. Highlighted to inform SAB, to be monitored and reviewed
	Green	Action on track and progressing to plan, no problems that will impact on schedule. No action required from SAB.
	Blue	Action fully completed

	RECOMMENDATION	ACTIONS	AGENCY	TIMESCALE	LEAD OFFICER	RAG
A		<ul style="list-style-type: none"> • 				<input type="checkbox"/> Red <input type="checkbox"/> Amber <input type="checkbox"/> Green <input type="checkbox"/> Complete
		EVIDENCE/PROGRESS				
		How will this be reviewed? What is the expected impact, timescales and results/outcomes – provide examples.				

	RECOMMENDATION	ACTIONS	AGENCY	TIMESCALE	LEAD OFFICER	RAG
B		•				<input type="checkbox"/> Red <input type="checkbox"/> Amber <input type="checkbox"/> Green <input type="checkbox"/> Complete
		EVIDENCE/PROGRESS:				
		How will this be reviewed? What is the expected impact, timescales and results/outcomes – provide examples.				

Repeat table rows as required

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