East Riding of Yorkshire Safeguarding Adults Board

Procedure for completing Safeguarding Adults Reviews

Safeguarding is everybody's business

Final 0.1.0

20 Nov 2019

East Riding Safeguarding Adults Board Version Control Template.

All documents produced by the East Riding Safeguarding Adults Board support function, whether electronic or hard copy will be uniquely identifiable. In many instances, it is necessary to track the changes that occur to a document throughout the document's development and subsequent revision(s). Version Control is the management of multiple revisions of documents via the use of a Document Control Sheet and Version Numbering incorporated into each document name.

The Version numbering system to be used by the East Riding Safeguarding Adults Board is the system that is based on the use of version numbers with points to reflect major and minor changes to a document.

The version number of a document in a draft format will start at 0.1 reflecting its draft status and then progress through revision by incrementing the number to the right of the point. The version number will convert to 01.0 upon the document/record receiving all required approvals, and deemed ready for publishing.

When the document has been approved and authorised ready for publishing the version number will start at 01.0, and the number will only be modified after the first minor amendment to become 01.1. A major revision to the document will result in the number to the left of the point incrementing by one and the number to the right of the dot point will return to zero e.g. 02.0.

Revision History:

Version	Date	Summary of Changes	Approved
0.1	13th March 2019	First draft to SARG members	
0.2	22 May 2019	Detailed discussion at SARG - further draft to include: • Learning from a local SAR • Clarity on role of the SAR Panel	
0.3	Sept 2019	Updates included from IMR/Chronology writing training	
0.1.0	**Nov 2019**	**Learning from ongoing SAR** **New guidance and protocol for involving families – agreed regionally**	**SAR Sub-group Nov 2019**

Contents

1 Introduction

The Safeguarding Adults Review Group (SARG) is a sub-committee of the East Riding Safeguarding Adults Board (SAB). The SARG is responsible for recommending the commissioning of SARs, managing the process and assuring the SAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

This document has been produced referencing the Leeds and Kirklees SAR Guidance and the Care Act 2014 Statutory Guidance section 42. It sets out the criteria for conducting a SAR and provides a menu of options for conducting those reviews. The associated guidance is designed to ensure governance of the process and to provide a local process for achieving a complex and challenging task more effectively.

2. The purpose of a SAR

SARs provide an opportunity to:

- Improve inter-agency working, for onward dissemination of lessons learnt to partner agencies
- Share best practice; and
- Ultimately, better safeguard adults at risk of abuse and neglect

The purpose of a SAR is to:

- **Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively**
- **Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and develop learning that enables the SAB to improve services and prevent abuse and neglect in the future**
- **Agree how the learning will be acted upon and what is expected to change as a result**
- **Identify any issues for multi or single agency policies and procedures, and**
- **Publish a summary report which is available to the public**

3. Criteria for conducting SARs

A SAR must always be conducted[1] (statutory SAR) when:

- An adult with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; OR
- If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

"Serious abuse or neglect" may include:

- the individual would probably have died but for an intervention,
- the individual suffered permanent harm as a result of abuse or neglect,
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect
- the individual has sustained a potentially life threatening injury through abuse or neglect,
- the individual has suffered serious sexual abuse.

This is not an exhaustive list. The final decision rests with the SAB or delegated SAR panel as to whether abuse/ neglect was serious enough to warrant a SAR.

There is no requirement for a case to have gone through a Section 42 safeguarding adult's enquiry before it can be considered for a SAR.

A SAR may be arranged (none statutory SAR) by the East Riding SAB for any other case involving an adult in its area with needs for care and support.

A none-statutory SAR should only be commissioned when it is clear that there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future.

Some examples of appropriate cases for a none-statutory SAR may include:

- Serious incidents that do not meet the criteria for a statutory SAR but that East Riding SAB wants to review
- A case featuring repetitive or new issues which the SAB wants to review in order to proactively identify areas of practice or issues to prevent serious abuse or neglect arising.
- A case featuring good practice in how agencies worked together to safeguard, from which learning can be identified and applied to improve practice and outcomes for adults.

The SARG will consider the issues raised within the case on behalf of the SAB and will carefully examine the potential for learning across agencies/services.

4. Principles

[1] Care Act, Section 44

The following principles apply to all reviews:

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

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

- The individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

- The Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and that appropriate action is taken to secure improvements in practice.

- SARs should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

- Professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

- SAR's should be completed in a timely manner and within six months unless there is a reason for a longer period e.g. ongoing court proceeding.

- SARs should all result in the production of an output, be it a full report, action plan, set of recommendations or similar.

- The findings from any SAR will be published in the SAB Annual Report along with the actions taken in relation to those findings.

5. Making a referral for a SAR

Any agency, professional or individual can make a referral for a SAR if they identify a case where they believe that the criteria for a SAR are met (**see section 3**). Examples of how a case might be identified are:

- Information presented on an initial safeguarding concerns form, or through further information gathering.
- During an ongoing Safeguarding enquiry/S42 a practitioner may identify a case.
- An agency may identify a case that has not had a safeguarding enquiry e.g. police may identify that a case they have been investigating meets the criteria for a SAR.
- The coroner, MP's and Elected Members of East Riding Council may have a case brought to their attention where they feel a SAR referral is appropriate.
- A health or social care professional or inspector/regulator visiting a provider may identify a concern of neglect which they think requires referral for a SAR.

6. Submitting a referral

The East Riding SAB is the only body that commissions SARs of adult safeguarding cases in the East Riding.

Requests for a SAR can be made in writing using the referral form attached as **appendix 2** which should be completed as fully as possible and returned to East Riding Safeguarding Adults Board at the secure email sab@eastriding.gov.uk. This will be taken for discussion to the next meeting of the Safeguarding Adults Review Group (SARG).

Alternatively a member of the Safeguarding Adults Review group can bring a case to the meeting of the SARG for a decision using the referral form and any additional information they have such as a concerns form or S42 enquiry report.

Where a professional or volunteer working for an agency is requesting a SAR the request should first go through their organisations appropriate management structure for sign-off, so that their organisation is aware that the request is being brought.

7. SARG Decision-making process

The SARG will need as much information as possible in order to make an informed decision. It is the responsibility of the person/agency making the referral to provide this information at the earliest opportunity.

If an agency/individual wishes to submit information which originates from another agency permission must be sought before doing so.

Types of information to submit to the SARG:

SAR referral form (this must be submitted)

Concerns form

S42 enquiry report

NHS Serious Incident Report

Police records

Photographs

Upon receipt of the request, the SARG will consider the referral at the next planned meeting. Alternatively, if the referral is deemed critical or severe enough to warrant an extra-ordinary meeting then the SAB support function will aim to arrange a meeting at short notice and agencies should try to prioritise this request.

If there is insufficient information on the request form to enable the SARG to make a decision some further information will be requested from the referrer. This will be via a discussion by a nominated SARG member with the individual who submitted the referral. This will be done in time for a decision to be made at the next planned SARG meeting, or sooner if it is deemed more urgent.

The SARG will then **make a recommendation** whether to conduct a SAR and if required will recommend which methodology should be used. Information on the types of methodology is contained later within these procedures and in **Appendix 1**.

8. Recommendation to the Chair of the SAB

The SARG will make its recommendation to the Chair of the SAB initially be telephone call and this will be followed up by an email outlining the basis for the decision, and this evidences the decision-making process. **This is the responsibility of the SARG Chair, however may be delegated by them to the SAB Board Manager.**

The final decision on whether to conduct a SAR is the responsibility of the SAB Chair.

9 Information Sharing

This SAR Procedure needs to read in conjunction with Care Act 2014, Section 45 Supply of Information, and be fully compliant with those circumstances where information is required from other persons to enable the SAB to exercise its functions. The following security measures must be taken by all individuals who are sharing information for the purposes of conducting the SAR:

- A confidentiality statement will be signed at each SAR Panel and any other meeting where a review is being discussed
- Information pertaining to a SAR will be marked as "SENSITIVE"
- Information will be transferred by secure email only
- Information about a SAR should not be stored alongside a person's normal health or social care records. They should be stored separately with limited access

10 Relationship to other reviews

When a case meets the criteria for a SAR an immediate task is required to find out whether there are other reviews or processes either taking placed or envisaged on the same case, such as

- Child Serious Case Review
- Domestic Homicide Review
- Police Criminal Investigation

- Sudden Fire Death review
- Coroner's inquest
- Learning Disability Reviews (LEDER)

Early contact will be made with the Chair/manager of any parallel process in order to

- determine how the reviews can be effectively managed to maximise learning for individuals and organisation; and
- avoid duplication for families and professionals.

Consideration will be given to -

- Whether the actions of all agencies and all aspects of the case could be effectively covered by one of the reviews
- Whether it would be appropriate for related reviews to be chaired by the same person
- Whether some aspects of related reviews could be commissioned or undertaken jointly
- Ensuring that the Terms of Reference for related reviews effectively cover all aspects of the case
- How to engage with adults, families and/or advocates to enable involvement and contribution to reviews and how their expectations can be managed appropriately and sensitively

11 Communications

Effective communications is a key part of the SAR process. It is important that whenever a SAR is to be conducted the communications leads in the different organisations are alerted. **This is the responsibility of the agency panel member.** This communication between panel members and communications lead will need to continue throughout the duration of the SAR and may need escalating to the point of producing a communications plan if it is decided that the final SAR report is to be published and if there is any chance of adverse media attention.

The East Riding Local Authority Communications team will be the lead organisation in guiding the communication requirements. This will include liaising with the Communications leads in the respective agencies and initiating and implementing an effective communications and media plan.

The communication plan will take account of communication requirements for a range of audiences/stakeholders, including:

- The family/families
- Between member organisations of the SAB

- The public
- The media

12 Recommending the overall approach/methodology to the SAR

When a decision is reached by the SAB Independent Chair that a SAR is to be conducted the SARG will consider whether it should make a recommendation as to the overall approach to a SAR or whether this should be left for the SAR Panel.

It may be that the SARG recommends some elements of the approach or specific requirements and asks the SAR Panel to recommend others. Each case will be dealt with according to its needs and any changes made as the SAR progresses will need to be agreed by the SAR panel and be documented.

There are many ways to achieve learning but the review must be proportionate in the approach it takes. A summary of some of the methodologies that may be used are contained in **appendix 1**. The list is not exhaustive and SARG or SAR Panel members may wish to use their collective expertise and recommend an alternative approach.

13 Deciding on the SAR Panel

A panel will be required to make decisions throughout the duration of the SAR and guide the SAR chair as it progresses. There are two options which can be taken within the East Riding.

- To use the current SAR sub-group as the SAR panel
- To set up an independent SAR Panel

The decision will be made depending on the case to be reviewed and the agencies who will be involved. The SAR panel is made up of the senior officers from the agencies who have provided services to the adult(s) who are subject of the review. These would normally have had no direct involvement with the adults concerned and are able to make decisions on behalf of their agencies.

The role of the panel is to oversee the progress of the SAR and make all decisions on next steps in consultation with the Chair. They will:

- Approve the SAR Terms of Reference (produced by the SARG) which will then be endorsed independently by the SAB Independent Chair
- Revise and amend the Terms of Reference as the SAR progresses depending on emerging factors
- Set timescales if not already determined
- Confirm which agencies need to be involved
- Identify, inform and establish links to any other processes ongoing or planned e.g. Police investigations
- Consider what legal or other expert advice is required
- Consider how the adult/s, advocate/s and or family members can be involved in the SAR

- Set all panel meeting dates and times
- Scrutinize and challenge all information submitted by each agency; specifically each agency's management report and chronology and further versions of them.
- Approve all relevant communications and media including who an how family members are involved and any media plans
- Comment on the initial draft of the Overview report and the final version prior to it being presented at the Board meeting
- Discuss and agree how the recommendations and learning identified will be formulated into an action.
- Ensure the learning is disseminated and shared within their own agency
- Agree what information is to be made public upon the conclusion of the SAR.

14 Commissioning an Independent Chair and report Author

The SAB Chair will make the final decision about commissioning an Independent Chair and report author. There may be occasions when the SAB Chair feels there is enough expertise to run an "in-house" SAR using the skills and experience of partner agencies. The SAB Chair will discuss this will partner agencies and agree an approach. However in most cases an Independent Chair will need to be appointed and the Board Manager will work with the council's Planning and Procurement team using the standard procurement procedures to appoint a suitable chair and agree their terms of reference.

Once the panel is agreed and the Panel Chair appointed an initial meeting will be required where the following will need to be discussed and agreed:

Panel Meeting 1

- Confirm which agencies should be asked to participate in the SAR
- Confirm whether the agencies concerned are required to secure their files
- Decide which methodology should be used to facilitate learning
- Set the Terms of Reference for the SAR and outline timescales
- Decide on the required output from the SAR (e.g. a report)
- Agree the timescales for completion of the SAR
- Discuss how and when to communicate the key messages of the review with the public/media
- Discuss how and when the adult and/or their family or advocate will be involved in the review and the level of their involvement and how they will be informed
- Agree when and how to communicate with the person/s who is alleged to have caused the abuse or neglect

15 SAR Terms of reference

When agreement has been reached that there will be a SAR, the SAR panel will need to draw up the terms of reference. In drawing up the terms of reference consideration should be given to the findings from information already seen or known and the concerns of staff, the adult, family members and others. Consider the following in agreeing terms of reference:

- What appear to be the most important issues to address
- What timescale should the SAR consider
- Which organisations are to be involved
- Is legal or other advice required (media?)
- How are adult/family/advocate to be involved and who will be the most suitable person for this role
- Are independent experts required
- Are there any specific considerations around ethnicity, religion, disabilities etc. that need considering.
- If possible involve the family in setting the terms of reference
- Identifying care and service delivery issues, along with the factors that might have contributed to them

The enquiry should stay within the terms of reference unless the terms are renegotiated with the SAR Panel. If this is the case any changes will need to be discussed with the SAB Chair.

Once a decision is reached on the methodology, the relevant agencies involved in the case will be requested to provide more detailed information about their contacts with the adult under review. In the majority of cases this will start with a **chronology** of contacts with the adult supplemented by detailed analysis which should include learning points, missed opportunities and best practice.

The Board Manager will contact all agencies on behalf of the SAB Chair to request the information required along with the timescale agreed by the Panel. A template letter to agencies is attached as **Appendix 5.**

The usual timescale for the completion of chronologies is 8 weeks however this is flexible and will be determined by the SAR Panel.

16 The Chronology

The chronology must be supported by some robust analysis such as any gaps in care/services identified, missed opportunities, areas of best practice etc. This will help the reviewers gain an appreciation of how and why aspects of care may have "gone wrong". Strong, robust chronologies may reduce the request for additional information.

The template chronology is embedded here – Agency Antecedent Chronology - Table.

To deliver good quality SARs the chronology needs to be more than a sequence of events by an individual agency then merged. It needs to act as a gauge to the overall quality of the service provided and whether this met or did not meet the required standards expected at the time.

Key points when completing the chronology

- Use when there is an antecedent chronology (story-line) leading to the incident under investigation.
- Use the format as issued by the Board as at some point there may be a need to merge them with other agency's chronologies
- Patient and staff identities **can** be used in the initial chronologies however they will **never** be used in either a combined chronology or any reports thereafter.
- The chronology writer should aim to rigorously analyse the involvement of their agency. Consider the actions taken or not taken and comment upon them.
- Try to get an understanding of not only what happened but why it happened.
- Facts should not be stated without their origin.

17 The combined chronology

The SAR panel will be required to make a decision about whether there would be any benefit in developing a combined chronology. This will be dependent on the number of chronologies involved and the timescale/detail of each chronology.

The SAB support function or SAR Chair will be responsible for producing a combined multi-agency chronology, based on the content and quality of the individual chronologies and the timescales by which it is required. **This will be determined by the Panel.**

18 The agency Individual Management Report (IMR)

The majority of SARs will require an IMR from those agencies who provided any care or support services to the adult/s who are the subject of the SAR. This is supplementary to

the chronology and provides some further in-depth analysis into what the data in the chronology is telling us.

IMRs are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice and areas where systems, processes, individual and group practice could be enhanced.

The Safeguarding Adults review group, having analysed the information on an initial case review request form, may also request a single agency to undertake an IMR and action plan where it is obvious that only a single agency has been involved in the case, and where there will be learning from completing an IMR.

The single agency method can be used as part of a "desk-top" review involving the individuals involved in the case and can be a relatively short piece of work which is not resource intensive. It is important that individuals who are asked to write IMRs as either a single agency tool or for a full SAR have the relevant skills to undertake this task. They should also be given support, access to all the relevant files and dedicated time to complete the task to timescale. They should also where possible be independent from the case being reviewed.

Key points when completing the IMR

- The author should begin with a statement about their organisations briefly covering the types of services it provides/commissions
- The author should include a brief overview of their own experiences including why they have been asked to complete the IMR
- Include the scope of the IMR – period reviewed/timescales
- Conduct of the IMR– methods used eg records, interviews etc
- Provide a summary of the chronology including key issues, lessons learned
- Produce a set of recommendations
- Include only recommendations which allow actions to be taken, improve practice and better safeguard adults
- Keep to the Terms of Reference which have been set

The IMR author will have to consider the key stages which need to take place within the 8 week timescale and prioritise this piece of work. Key stages of the process include:

- **Sourcing records**
- **Reading records**
- **Interviewing staff**
- **Completing the first draft**

- **Proof reading**
- **Completing recommendations**
- **Obtaining internal sign-off/governance**

It is also best practice for staff involved in the case particularly those who were interviewed, to be de-briefed about the report – what is it showing, where is it going and what will happen next.

It is also best practice for those who were involved in writing the IMRs to be invited to a panel meeting to present their findings in a well-managed confidential environment.

The SAR Independent overview author should offer support to IMR authors throughout the process so that they are kept on track and feel confident that they will produce a robust report.

The template IMR report is attached here:

IMR Report Template.docx

19 Conducting the SAR

These procedures have so far outlined the details for a number of stages in the SAR process including:

- How to refer a case for consideration
- The SAR decision making process
- Approaches and methodology
- Deciding on a SAR Panel
- Commissioning an Independent Chair
- Setting the terms of reference
- Chronologies and IMRs

How the SAR progresses hereafter is for the decision of the SAR Chair agreeing all next steps with the SAR panel. The SAR Panel supported by the SAB Manager is responsible for the following:

- Setting SAR panel meeting dates and agendas as required.
- Arranging venues as required for the duration of the SAR.
- Inviting all nominated representatives from relevant agencies to SAR panel meetings.
- Ensuring the review is conducted according to the terms of reference and methodology.
- Notifying East Riding SAB of any administrative/resourcing arrangements that may require further negotiation.
- On-going liaison with the police and/ or coroner's office as required.

- Initiating the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice.
- Requesting any additional data/evidence/reports from partner agencies as required.

There is no set number of panel meetings for a SAR as this is dependent on the nature and scale of the case, any other parallel enquiries and the speediness at which agencies produce the required information. A pragmatic approach should be taken including the use of telephone discussions between meetings and other mechanisms for reaching decisions without the use of a full Panel meeting.

20. Engagement of the adult, family or advocate

Reflecting the principles of openness, transparency and candour; the SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care Act 2014, where an adult has "substantial difficulty" in participating, this should involve representation and support from an independent advocate.

The SAR Panel needs to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how a known abuser might have some input to the review process. To maintain independency from agencies involved, the SAR Independent Chair and Author will undertake any engagement with the person/people alleged to have caused the abuse.

The adult, a family member/friend representing them or an independent advocate will be notified in writing that a decision has been made to undertake a SAR. A letter will be sent from the Chair of the Panel explaining why the SAR is being undertaken and will provide a contact telephone number for the adult to speak to discuss whether they would like to be involved and offering support throughout the process. The standard template letter should be adapted to the individual circumstances of the case and sent to the most appropriate person. The template letter is attached as **appendix 3**.

Along with the letter there is an information leaflet for families which may help people understand what the review process is about and whether they would like to be involved. The person who has built up the best relationship with the adult or the family should be the named contact for their involvement. The information leaflet for families is attached as **appendix 4.**

Reasonable and appropriate support and adjustments should be made by East Riding SAB to enable the adult(s), their family and/or representatives to participate in the SAR. This may include but is not limited to:

- Easy read, large print and/ or translated materials.
- Access to an interpreter.
- Support from a chosen chaperone or representative.
- Longer meeting times

- Pre-meeting briefings and post-meeting de-briefs.
- Access to an independent advocate.

If there is no appropriate person to support and represent the adult(s), then East Riding Council must arrange for an independent advocate (under Section 68 of the Care Act). Alternatively if an advocate is already provided under another arrangement such as a Mental Health Advocate then this advocate should be used for engagement in the SAR.

If there are ongoing Police investigations consideration will need to be given as to how and when it is appropriate to speak to the adult/s, family members and others as speaking to them too early may risk contaminating Police evidence. In these cases a meeting with the Police investigating officer, the SAR Chair and the SAB Independent Chair is required, as a minimum with additional representation required depending on the case.

Engagement where there is more than one individual involved

In cases where there is more than one individual involved such as large scale/whole service issues a process will need to be agreed by the Panel as to how best to involve the adults, families and/or advocates. This could be through a series of workshops, engagement events or meetings where the adults are invited to take part should they wish. This needs careful thought and should meet the needs of anyone who wishes to take part. The following principles apply:

- Process agreed by the Panel
- Engagement undertaken by the Independent Chair/Author
- Location to be best suited to the needs of the adults
- Reasonable adjustments to be made as appropriate

The Association of Directors of Social Services (Yorkshire & Humber) has produced a document: Involving People in Safeguarding Adult Reviews Protocol which describes the principles to be followed when there is a need to involve people in SARs. The document is embedded below

SAR Involvement Protocol - ADASS YH

21 Staff Involvement

As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers and their line managers. It should be made clear that the review process can be lengthy, and may be delayed if police investigations are ongoing.

It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so that real learning and improvement can happen. Staff should be told clearly that the SAR is an opportunity to learn from the case and it is not about blaming individuals. An appropriate safe environment should be provided for this.

If there are ongoing Police investigations consideration will need to be given as to how and when it is appropriate to speak to some members of staff as speaking to them too early may risk contaminating Police evidence. In these cases consideration could be given to having a meeting with the Police investigating officer, the SAR Chair and the SAB Independent Chair, as a minimum with additional representation required depending on the case. There should be accurate records taken at this meeting.

Interviewing staff

It is the role of the IMR report author to conduct the necessary interviews with staff in order to obtain as many views as possible from key staff involved at the time the alleged abuse took place. Senior staff within the agency/ies involved will be able to make informed decisions about which staff members should be interviewed and they should be given appropriate support throughout the interview process. It may be better to call this a "protected time discussion" rather than an interview. As with other parts of the SAR process, some key principles apply:

- **Choose a comfortable location which the interviewee has agreed**
- **Provide an necessary reasonable adjustments**
- **Send the questions to them beforehand so there are no surprises**
- **Use a tape recorder/Dictaphone if necessary/agreed**
- **Allow them to bring a friend/colleague/Union rep**
- **Make sure everything is kept confidential**
- **Send the interviewee a record of their transcript for verification purposes.**

22. Disclosures to regulatory bodies

Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

23 The final report

The SAR concludes with an Overview Report with recommendations produced by the Independent SAR Chair. There may need to be an interim overview report produced first depending on the progress of the SAR and this will be decided by the SAR Panel. A proportionate approach should be taken in all instances. This needs to be written as soon as possible and in a way that is accessible and understandable to all readers.

The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR Panel should form the basis of any SAR report.

The report should:

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials and document name;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest (seek legal advice);
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable;
- Include a description of how patients/victims and families have been engaged in the process;
- Include a description of the support provided to patients/victims/families and staff following the incident.

24 Governance of the final report

The SAR Panel will receive and agree the draft report before it is presented to the East Riding SAB. This is so that individuals are satisfied that the Panel's analysis and conclusions have been fully and fairly represented.

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

Any adjustments will be considered before the final Overview report is then presented at the next scheduled SAB meeting by the Independent Author. This provides an opportunity for the full SAB to scrutinise all aspects of the SAR including the content and quality.

The East Riding SAB will decide whether to report in full, or in part should be made available to the wider public, and the means by which this will be done. This could include publication via the East Riding SAB website. If the report is published it will be fully anonymised.

In line with Schedule 2 of the Care Act 2014 findings from SARs conducted will be reported in the SAB Annual Report.

25. SAB Function after a SAR

East Riding SAB will translate learning from the SAR report into recommendations and a proposed multi-agency action plan if required, which should be endorsed at senior level by each organisation to whom it relates. The SAB may decide not to implement a recommendation(s) and will record reasons for this.

- The multi-agency action plan will indicate:
- The actions that are needed.
- Responsibilities for specific actions.
- Timescales for completion of actions.
- The intended outcomes: what will change as a result?

- Mechanisms for monitoring and reviewing intended improvement
- The processes for dissemination of the SAR report or its key findings.

Individual agencies may also be asked by the SAB to produce their own internal action plans if required and report progress back to the SAB.

Board members are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is embedded in their own organisation. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.

East Riding SAB will monitor progress on all recommendations (or delegate to an appropriate sub- group). It may also request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

26 Applying the learning from other SARs

East Riding SAB is committed to the regular analysis of the themes and learning from national high-profile SARs and relevant other SARs as selected by the SAR Sub-Group.
Members of the SAR sub group can present to the group cases which they think are relevant for this process. Alongside this the SAB support function will research key themes and learning from SARs nationally and from the National SAR Library and present findings from a case to the Sub-Group. Learning from SARs will also be discussed at the Learning and Improvement sub-group and where applicable with the East Riding Safeguarding Children's Partnership.

Appendix 1

Safeguarding Adults Review (SAR) Methodologies

Methodologies

There are many ways to achieve learning; guidance from the Association of Directors of Adult Social Service (ADASS) and the NHS emphasises the importance of proportionality in conducting reviews, and with this in mind flexible options are available to match the circumstances of the case.

Each methodology is valid in itself, and no approach should be seen as more serious or holding more importance or value than another.

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 being seriously abused or neglected.

The menu of SAR methodologies[2] set out below includes the following six options:

- Systems analysis
- Learning together
- Significant incident learning process
- Significant event analysis/ audit
- Appreciative inquiry
- Safeguarding Adults Review (traditional methodology)

On the following pages, a resume of each methodology is provided, along with key features assist decision-making. Links are provided to identified available models, which can be used to download tools and guidance

The menu is not an exhaustive list. The SARG should use its collective skills, experience and knowledge to recommend the most appropriate learning method for the case. SAR panel chairs must not be too rigid or constrained by the methodology chosen – chairs may allow a degree of flexibility within each methodology, allowing SAR panel members to do things slightly differently where appropriate

[2] Adapted from Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015)

Option A: Systems Analysis

Key features:

- Team/ investigator led
- Staff/ adult/ family involved via interviews
- No single agency management reports
- Integrated chronology
- Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	**Disadvantages**
Structured process of reflection	Burden of analysis falls on small team/individual rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions
Reduced burden on individual agencies to produce management reports	Staff/family involvement limited to contributing data, not to analysis
Analysis from a team of reviewers may provide more balanced view	Potential for data inconsistency/conflict, with no formal channel for clarification
Managed approach to staff involvement may well fit well where criminal proceedings are ongoing	Unfamiliar process to most SAB members
Enables identification of multiple causes/contributory factors	Trained reviewers not widely available
Focusses on areas with greatest potential to cause future incidents	Structured process may mean it's not light touch
Based on thorough academic research and review	RCA may be more suited to single events/incidents and not complex/multi agency issues
RCA tried and tested in healthcare and familiar to health sector SAB members	

Available models:

Vincent et al (2003) Systems analysis of clinical incidents: the London Protocol

http://www1.imperial.ac.uk/cpssq/cpssq_publications/resources_tools/the_london_protocol/

NHS Patient Safety Agency (NPSA) Root Cause Analysis

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Option B: Learning together

Key features:

- Lead reviewer led, with case group
- Staff/ adult/ family involved via case group and 1:1 conversations
- No single agency management reports
- Integrated narrative; no chronology
- Aims to identify underlying patterns/factors that support good practice or create unsafe conditions

Advantages	Disadvantages
Structured process of reflection	Burden of analysis falls on small team/individual rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions
Reduced burden on individual agencies to produce management reports	Challenge of managing the process with large numbers of professionals/families involved
Analysis from a team of reviewers and case group which may provide a more balanced view	Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnessed
Staff and volunteers participate fully in case group to provide information and test findings	Cost- either to train in-house reviewers or commission SCIE reviewers for each SAR
Enables identification of multiple causes/contributory factors	Opportunity costs of professionals spending large amounts of time in meetings
Tried and tested in Children's Safeguarding	Unfamiliar process to most SAB members
Pool of accredited independent reviewers available and opportunity to train in-house reviewers to build capacity	Structured process may mean it's not light touch

Available models:

SCIE Learning Together

http://www.scie.org.uk/children/learningtogether/

Option C: Significant Incident Learning Process (SILP)

Key features:

- Review team and learning day led
- Staff/ family involved via learning days
- Single agency management reports
- No chronology
- Multiple learning days over time
- Explores the professionals' view at the time of events, and analyses what happened and why

Advantages	**Disadvantages**
Flexible process of reflection – may offer more scope for taking a light-touch approach	Burden on individual agencies to produce management reports
Transparency facilitates staff and family participation in a structured way which is easier to manage large number of participants	Cost – either to train in-house reviewers or to commission SILP reviewers for each SAR
Has similarities to traditional SCR approach so more familiar to most SAB members	Opportunity costs of professionals spending large amounts of time in learning days
Agency management reports may better support single agency ownership of learning/ actions	Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
Trained Significant Incident Learning Process (SILP) reviewers available and opportunity to train in-house reviewers to build capacity	Not being wisely tried or tested, not gone through academic research or review

Available models:

Tudor, Significant Incident Learning Process

Option D: Significant Event Analysis (SEA)

Key features:

- Group led (via panel), with facilitator
- Staff/ adult/ family involved via panel
- No chronology
- No single agency management reports
- One workshop: quick, cheap
- Aims to understand what happened and why, encourage reflection and change

Advantages	**Disadvantages**
Light touch and cost effective	Not designed to cope with complex cases
Yields learning quickly	Lack of independent review team may undermine transparency /legitimacy
Full contribution of learning from staff involved in the case	Speed of review may reduce opportunities for consideration
Shared ownership of learning	Not designed to involve the family
Reduced burden on individual agencies to produce management reports	Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
May suit less complex or high profile cases	
Trained reviewers not required	
Familiar to health colleagues	

Available models:

National Patient Safety Agency SEA

Care Quality Commission SEA

http://www.cqc.org.uk/content/gp-mythbuster-3-significant-event-analysis-sea

Royal College of General Practitioners SEA

http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement/significant-event-audit.aspx

Option E: Appreciative Inquiry

Key features:

- Panel- led, with facilitator
- Staff involved via panel. Adult / family involved via meeting.
- No chronology/ management reports
- Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Advantages	**Disadvantages**
Light touch, cost effective and yields learning quickly. Process can be completed in 2-3 days	Not designed to cope with poor practice or systems failure cases
Staff who worked on the case are fully involved	Adult/family only involved via a meeting
Shared ownership of learning	Speed of review may reduce opportunities for consideration
Effective model for good practice cases	Model not well developed or tested in safeguarding.
Some trained facilitators available	Minimal guidance available
Well researched and reviewed academic model	
Model understood fairly widely	

Option F: Safeguarding Adults Review: Traditional Methodology

Key features:

- Panel- led with independent author/chair
- Staff/adult/family involved via case group and 1:1 conversations
- Single agency management reports
- Single agency, no chronologies, then considered
- Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions

Advantages	Disadvantages
Structured process of reflection	Burden on individual agencies to produce management reports
Analysis from a panel and may provide a more balanced view	Challenge of managing the process with large numbers of professionals/family involved
Staff and volunteers participate fully in case group to provide information and test findings	Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
Enables identification of multiple causes/contributory factors	Cost – either to train in-house reviewers or commission SCIE reviewers for each SAR
Familiar process to SAB members and wider partners	Opportunity costs of professionals spending large amounts of time in meetings
Range of pre-existing analysis tools available	Structured process means it's not light-touch
Applicable if the case also meets the criteria for a Domestic Homicide Review (DHR)	

Available model: SCIE, Learning Together
http://www.scie.org.uk/children/learningtogether

Appendix 2

SAR Referral Form

Referrers' Details

Name	**Designation**	**Agency**	**Contact details (email & telephone)**

Manager sign-off **Name & title of Manager approving this referral:**

Details of the adult at risk – complete all the information known to you at this time

Name	
Date of Birth	
Date of death (if the adult has died)	
Date of incident	
Gender	
Ethnicity	
Address	
Brief details of the adults physical health	
Brief details of the adults mental health	
Agencies involved with the adult	

Details of the person/s or organisation/s alleged responsible to have caused the harm or neglect – please provide the details known to you at this time

Name/s	
Address	

Family and significant others

Name	Relationship to adult

Please outline the circumstances of the incident (death, injury, referral to safeguarding). Include in this section what happened, where it happened, what are your main concerns and if possible include dates, times and locations. If you are aware if a safeguarding enquiry/S42 or any other type of enquiry has already taken place please also include details.

Circumstances of the incident:

Add additional sheets as required

Your agency's & other agencies involvement with this adult.
Outline below your agency's involvement with the adult at risk, their family, carers and any other significant people. Also include areas of concern about other agencies involvement/lack of involvement which may have impacted on this incident.

Agencies involvement with the adult:

Is the adult/family/advocate aware that this request for a SAR is being made (if applicable?)

Yes ☐ **No** ☐

Criteria for undertaking a Safeguarding Adults Review:

Please tick the appropriate box that explains why this case requires a Safeguarding Adults Review:

Tick √	**Criteria relevant to this case**
	An adult at risk has died as a result of abuse or neglect, whether known or suspected **and** there is concern that partner agencies could have worked more effectively to protect the adult.
	An adult at risk has not died, but the Safeguarding Adults Board knows or suspects that the adult at risk has experienced **serious** abuse or neglect.
	The SAB are also free to consider conducting a SAR into any incident(s) or case(s) involving adults at risk. E.g. where it is believed to be in the public interest to conduct such a review.

	The request is being made by a Coroner, Family, Government Ministers or other interested parties seeking a SAR to establish whether there are important multi-agency lessons to be learned.

Email the completed form to: sab@eastriding.gcsx.gov.uk

Appendix 3

Standard Template letter to the adult or family member/advocate

Addressee
Date

Re: East Riding Safeguarding Adults Board – Safeguarding Adults Review (SAR)

Dear

(In the case of a death only) First of all I would like to offer my sincere condolences on the death of (adult's name).

The purpose of this letter is to inform you that because of **(insert circumstances)** ********** and the circumstances surrounding this, East Riding Safeguarding Adults Board (SAB) will carry out something called a Safeguarding Adults Review.
I would like to reassure you that this Safeguarding Adults Review will not influence any ongoing police investigations, or any work that may be happening at the moment between your family and professionals such as a social worker. This is a separate process, involving senior managers from all Health and Social Care Services that make up the SAB.
The purpose of the Safeguarding Adults Review is:

 To establish whether there are lessons to be learned about the way in which local professionals or organisations work together to safeguard and promote the welfare of adults at risk

 To identify clearly what those lessons are, how they will be acted upon and what changes might be necessary

 To improve inter agency working and better safeguard adults at risk.

I have enclosed a leaflet which outlines the process for the Safeguarding Adults Review.
Please do not hesitate to contact xxxxxxxxxxxxxxxxx if you would like to be involved in the Safeguarding Adults Review so we can discuss how you would like involving, or if you want any further information.
You may want to take independent legal advice before making any decisions about all of this. If you decide to do this and your solicitor has any queries he or she is also welcome to contact the above mentioned person.

Yours sincerely

Chair of the SAB

Appendix 4

Leaflet for Families

Safeguarding Adults Reviews: Information for Families

What is East Riding Safeguarding Adults Board (SAB)?

East Riding Safeguarding Adults Board brings together all the main organisations who work with adults at risk and their families in our area to keep them safe.

What is a Safeguarding Adults Review?

A Safeguarding Adults Review looks at how local organisations worked together to look after the adult at risk at the centre of the review. It may also look at how they are working with other adults at risk in the immediate family or care settings. The review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is not a Criminal Investigation or Public Enquiry and its aim is not to place blame but to learn.

Why Are You Carrying Out A Safeguarding Adults Review?

East Riding Safeguarding Adults Board will carry out a SAR whenever an adult at risk has been seriously harmed or has died in circumstances where abuse or neglect is suspected or confirmed. There is an Act called the Care Act 2014 which states the cases in which we **must** carry out a review and this case meets the criteria.

Who Will Carry Out the Review?

A panel of professionals from Community and Adult Care Services, the Health Service, the Police and sometimes other organisations are led by an independent person (the 'Author'). They will meet to review reports from each organisation or agency which has worked with or provided services to the adult at risk or their family. The Author will prepare a report. This report will say what lessons have been learnt and make recommendations for East Riding Safeguarding Adults Board.

What Will Happen after the Report is finished?

East Riding Safeguarding Adults Board will write an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. Each individual organisation involved in the review will also write an action plan. East Riding Safeguarding Adults Board will make sure the actions are carried out and have a positive effect.

What Will I / We Have To Do?

You do not have to do anything. However, you will have the opportunity to give your views if you would like to. We will make sure that there is someone who can help you to do this (see contact details below).

Who Will See the Report?

Normally the Report will be kept confidential to those people who represent their organisations at East Riding Safeguarding Adults Board or have contributed to the review and the staff within those organisations who worked with the adult at risk and their family. The Executive Summary sets out the key findings and recommendations of the review. It does not give any personal details or information which would identify the adult at risk, family or anyone else involved. It is available to anyone who

wants to read it and will be on our web site. Your personal contact will meet with you and tell you what is in the Executive Summary before it goes on the website.

How Long Will the Review Take?

The review will be undertaken as quickly as possible. However, in some cases it can take six to nine months from the start of the review to publication of the Executive Summary.

In this leaflet we have answered some of the most frequently asked questions families have about Safeguarding Adults Reviews. Of course, each case is different and you may have other questions you would like to ask. If so, you can contact the person named above in your letter or you can contact the Safeguarding Adults Board Manager.

East Riding Safeguarding Adults Board
01482 392092
Email: ersab@eastriding.gcsx.gov.uk

Letter to agencies

Appendix 5

Independent Chair
Safeguarding Adults Board
County Hall, Cross Street,
Beverley.
HU17 9BA

Insert date

Strictly Confidential

Chief Executive Officer
Agency Name
Address line 1
Address line 2
Town
Post code

Dear (insert name)

Re: Safeguarding Adult Review-Adult at Risk of Harm.

The purpose of this letter is to notify you that it is the intention of the East Riding Safeguarding Adults Board (SAB) to undertake/commission an Adult at Risk of harm Safeguarding Adult Review (SAR) and your agency may be able to contribute/support the review process. Your East Riding Safeguarding Adults Board representative (insert name) has been sent a similar communication via email; the subject matter of this letter is not in the public domain.

Following a recommendation by the SAB Safeguarding Adult Review Sub-Group, I decided that a Safeguarding Adult Review will be required to examine the way agencies worked together to safeguard (insert very brief details of case).

The subject of the review will be: Insert adults name

DoB:

Terms of reference, appointment of independent chair/report author and membership of the Case Review Panel will be agreed and circulated in due course. At that time it may be necessary for your agency to identify a manager (or independent person) of sufficient seniority and experience to take part in the review. The manager appointed should have had no line management relationship with practitioners working with the person concerned or any direct contact themselves with the adult at risk of harm. It would be helpful if they have had some experience in undertaking reviews.

The purpose of a safeguarding adult review is to establish whether there are any issues in relation to inter-agency working under the local safeguarding adults procedures, and if there are any lessons

to be learnt about the way they operated. To achieve this, each agency that has had involvement is required to look openly and critically at their professional practice with the adult concerned.

The information which is requested from your agency to begin the SAR is as follows:

(description to be inserted here dependent upon type/scale of SAR)

I will ensure your board representative is contacted in due course with an update in respect of the terms of reference and the necessary next steps. Should you require further information before then please feel free to contact me.

Yours Sincerely

Independent Chair

East Riding Safeguarding Adults Board

Email:

Contact Officer

Board Manager

East Riding Safeguarding Adults Board.

Tel:

Email: