Southwark Safeguarding Adults Partnership

# SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

## Protocol for Requesting and Conducting a Safeguarding Adult Review in accordance with Section 44 Care Act 2014

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# 1. INTRODUCTION

1.1 Section 44 of The Care Act 2014[1], requires that Safeguarding Adult Boards (SSAB) are responsible for Safeguarding Adult Reviews (SAR). Paragraphs 14.162 to 14.179 of the Care and Support Statutory Guidance[2] sets out in more detail the principles, definitions and outlines a framework for when certain events happen.

1.2 The SSAB must arrange a SAR when an adult 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. The SSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. The specific criteria are set out in paragraph 4.2 and on Form A, Appendix 1 of this document.

1.3 The SSAB is free to arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

1.4 The adult who is the subject of the SAR need not have been in receipt of care and support services for the SSAB to arrange a review in relation to them. If they are able and chose to, they should be fully involved throughout the process (see Section 10 below).

1.5 This SAR Protocol has been put in place by the Southwark SSAB to support the effective identification of and response to SARs within the Borough and to support the Board in discharging its statutory duty. The Protocol describes the process to follow, and is informed by the statutory text and complements the London Multi-agency Safeguarding Adults Policy and Procedure

1.6 It is important to stress that a SAR is not a 'second stage' safeguarding process and is usually reserved for the most significant of issues.

[1] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
[2] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

## 2. SAFEGUARDING ADULT REVIEW OPERATING FRAMEWORK AND GOVERNANCE

2.1 Southwark (SSAB) Safeguarding Adults Board (SSAB) has the lead responsibility for carrying out a Safeguarding Adult Review (SAR) based upon receipt of a referral (see below within the relevant section and within the appendices for supporting documentation).

2.2 The SSAB has delegated management of this responsibility to its Quality and Performance Subgroup, which is responsible for receiving and considering SAR referrals. The Subgroup is chaired by the Director of Quality and Chief Nurse of the NHS Southwark CCG. The Quality and Performance Subgroup membership is made up of the statutory members of the SSAB (the Council, Police and CCG), with specific Terms of Reference that are annually reviewed. The Subgroup reports to the SSAB.

2.3 The Subgroup meets on a planned basis throughout the year, but a meeting will be convened as soon as is practical upon receipt of a referral or in an on-going basis to act as a co-ordinating group to any SARs in progress.

## 3. PURPOSE OF A SAFEGUARDING ADULT REVIEW

3.1 The purpose of a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an enquiry into how an adult died nor is it to apportion blame; but to learn from such situations, and that those lessons are applied to future cases to prevent similar harm occurring again.

3.2 Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

3.3 It will be highly likely that a safeguarding process will have been followed in relation to the circumstances. The SAR is for consideration of the most serious issues, and will not be an alternative to a safeguarding enquiry, investigation or process.

3.4 The purpose of conducting a SAR is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults.
- Review the effectiveness of procedures and their application (both multi-agency and those of individual organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

3.5 It is acknowledged that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these, but it does remain a statutory requirement in its own right and will be complemented by other such processes.

3.6 Where there are possible grounds for other review processes to be activated (e.g. Domestic Homicide Review, Child Serious Case Review, Health Serious Incident) a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair, with a final joint report being taken to all the relevant review commissioning bodies. However it must be remembered a SAR is a statutory requirement and will be required to be undertaken as much as other processes.

# 4. CRITERIA FOR SAFEGUARDING ADULT REVIEW

4.1 In summary, the SSAB has the lead responsibility for arranging and conducting a SAR and **must** do so when:

- An adult 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.
- If the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

4.2 "*Serious abuse or neglect*" may include where:

- the individual would have been likely to 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,

4.4 The SSAB **may** also consider a SAR in other specific circumstances outside of the statutory requirement, including where, for example:

- A case featuring repetitive or new concerns or issues which the SSAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

4.5 Any agency or professional body, together with the Coroner, may refer such a case to the SSAB seeking a SAR to establish if there are important lessons for inter-agency work to be learnt from any given case. (For how to make a referral, see Appendix 1).

4.6 Specifically, Section 44 of the Care Act 2014 states:

1. *"An SSAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if,*
   *(a) there is reasonable cause for concern about how the SSAB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***and***
   *(b) condition 1 or 2 is met.*
2. *Condition 1 is met if:*
   *(a) the adult has died, and*
   *(b) the SSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*

3. *Condition 2 is met if:*

   *(a) the adult is still alive, and*

   *(b) the SSAB knows or suspects that the adult has experienced serious abuse or neglect.*

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

# 5. REQUESTING THAT A SAFEGUARDING ADULT REVIEW BE UNDERTAKEN (REFERRAL)

5.1 Any agency, individual or professional may consider that a case meets the criteria for a SAR and request that one be undertaken. It is expected that any request is first considered by the agency or organisation for whom the professional works, and that the most senior manager or their SSAB representative makes any formal referral. (The prospective referrer may find it helpful to discuss the issue with Southwark's Head of Adult Safeguarding, or NHS Southwark CCG's Director of Quality and Chief Nurse). In all cases, it is expected that the criteria in Section 4 is fully considered before making any referral.

5.2 It is important to note the SSAB will only consider cases *"in it's area"* as per Section 44 of The Care Act. In practice this means it will consider cases which relate to people residing within the Southwark Borough (which includes people who have been placed by other Boroughs or Clinical Commissioning Groups into the Southwark locality). Should a person placed by Southwark Clinical Commissioning Group or Southwark Council in another area be the subject of circumstances that would be a SAR, then it would be for the SSAB of that locality to carry out and oversee a SAR. In such circumstances, Southwark agencies may have to make the relevant approach or referral to the SSAB of the relevant locality.

5.3 The formal referral to the SSAB should be made using the Referral Notice form in Appendix 1 which should be sent to the Chair of Southwark Safeguarding Adults Board. Details for submission are set out on the form in Appendix 1.

5.4 The Manager of SSAB will inform the Chair of Quality and Performance Subgroup of receipt of SAR referral. A copy of the referral will be sent to the Subgroup Chair who will review the information contained in the referral against the criteria and will agree to convene the Subgroup to consider the merits of the referral.

5.5 In deciding whether a referral should progress to a SAR, the Subgroup may find it useful to invite the referrer to the Quality and Performance Subgroup meeting to present their completed referral, allowing the Subgroup to clarify matters as required.

5.6 If the issue under consideration is also the subject of a Police investigation or judicial process, then the Quality and Performance Subgroup will need to be advised or will seek to identify this before considering the next steps. Equally where an issue triggers a mandatory investigation or review within an organisation (e.g. NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. In all such cases, legal advice may be appropriate to guide the decision making

# 6. DECIDING TO UNDERTAKE A SAFEGUARDING ADULT REVIEW

6.1 The Subgroup remains responsible to the SSAB. The Chair of the SSAB has ultimate responsibility for deciding whether or not to conduct a SAR.

6.2 In deciding if a SAR should be undertaken, the Quality and Performance Subgroup will refer to Section 4 above.

6.3 Once a referral is received, considered and Quality and Performance Subgroup agrees that a SAR should be instigated, the Chair of the Subgroup will notify the SSAB Chair of the recommended actions that should then follow. This decision to proceed (or not) will be made ideally within 14 days but no later than one month. In all situations the notice of the referral and the decisions that follow will be raised at the next SSAB and recorded.

6.4 If the recommendation of the Quality and Performance Subgroup is not to proceed to a SAR, the Subgroup may consider whether to request an alternative review or a smaller-scale audit of agency involvement. In such cases, arrangements should be made for the agency to share relevant findings with the Quality and Performance Subgroup or other appropriate body. The SSAB Chair will be notified of the referral and Subgroup decision.

6.5 If the Chair of SSAB does not agree with the recommendation of the Quality and Performance Subgroup (proceed or not proceed), a meeting should be convened with the Chair of the Subgroup to try to resolve the issue as a matter of urgency. If necessary, a special meeting of the full SSAB should be convened to make a final decision.

6.6 Whatever the ultimate decision, the referrer should be notified by letter from the Chair of the Subgroup, within a reasonable time scale. If the SAR is not to proceed, then the letter should outline the reasons for the decision.

6.7 All such decisions and actions, including those that are taken by the Subgroup or a convened SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, and Accountability – see Care Act Statutory Guidance and London Multi-Agency Safeguarding Adults Policy and Procedures for more details).

6.8 Once a confirmed decision has been made to instigate a SAR, the chair of Quality and Performance subgroup will ensure that the NHS England is informed through STrategic Executive Information System (STEIS). The Care Quality Commission (CQC) will also be notified.

# 7. SELECTING THE MOST APPROPRIATE METHODOLOGY FOR THE CASE IN QUESTION

7.1 Once it has been agreed to commission a SAR, the most appropriate methodology to use should be considered. Different methodologies will suit different types of circumstances. The Chair of the Quality and Performance Subgroup will discuss with the appointed Independent Chair of SAR Panel what methodology will be used for the SAR. Any methodology chosen must be proportionate to the case under review. The Care and Support Statutory Guidance indicates that, whichever methodology is employed, the following elements should feature:

(A) **SAR Panel Chair,** that is independent of the case under review and of the organisations whose actions are being reviewed. They should have the appropriate skills, knowledge and experience, which will include:

- Strong leadership and ability to motivate others
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
- Good analytical skills using qualitative data
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge and experience
- Commitment to/ promotion of open and reflective learning cultures.

(B) **SAR Panel of relevant and nominated people** who will contribute to and scrutinise information submitted, in the form agreed. The panel size should be proportionate to the nature and complexity of the review.

(C) Clear **Terms of Reference,** setting out what is the focus and scope of the SAR (and where appropriate, what is not within scope); times frame within which the SAR will focus; roles and expectations and outcomes required. (See Appendix 6)

(D) **Early discussions with the adult and their family/carers** to agree to what extent, how they wish to be involved and to manage expectations. This includes access to independent advocacy if required (See Section 9)

(E) **Appropriate involvement of professionals and organisations who were working with the adult** so they can contribute their perspectives without fear of being blamed for actions they took in good faith (See Section 10)

(F) **A final report and recommendations,** which effectively sets out the specific and wider learning considerations (See Appendix 7)

7.2 Whatever methodology that is used must provide the most effective learning mechanism and best enable the involvement of key agencies and staff as well as those who are connected to the person (e.g. family etc.). It must also be balanced against the cost, resources and length of time required to conduct the review and the subsequent outcome required.

# 8. INITIATING AND CONDUCTING A SAFEGUARDING ADULT REVIEW

8.1 As soon as it has been established and agreed that a SAR should take place the Quality and Performance Subgroup will need to consider which agencies should be involved, especially as some may not be immediately obvious. In doing so the Subgroup will use its best endeavours to identify the agencies that should be approached and the process by which it will do so.

8.2 In instigating the SAR process, the Chair of the Subgroup, will on behalf of the SSAB:

8.2.1 Write to the Senior Accountable Officer[3] of each relevant involved agency (copying in their SSAB representative/ Safeguarding Adult lead) advising them that their agency's records relating to the adult at risk in question need to be secured with immediate effect. They will also be asked to nominate a representative for any SAR Panel that is subsequently convened.

8.2.2 Confirm any specific actions required of the agency in preparation for the SAR such as the need to prepare for any Individual Management Review (IMR) using Letter A (see Appendix 4). The templates for completing the chronology and the analysis components of the Individual Management Review (See Appendix 2) will be conveyed to the agency.

8.3 As part of the considerations for commencing a SAR, the SSAB will identify and appoint an appropriate Independent Chair of the SAR Panel with sufficient standing and expertise, ensuring there is no conflict of Interest.

8.4 The Independent Chair, in conjunction with the Subgroup will:

- Draft the Terms of Reference for the SAR, including the period for which the SAR will focus
- Confirm which partner agencies should be part of the SAR Panel.
- Consider how the adult at risk (where he or she has survived) will be supported and involved in the SAR process.
- Confirm how relatives, family or friends will be involved in the SAR and who will act as liaison and support to them.
- Confirm arrangements for any on-going support (e.g. legal support)
- Agree the outline communication plan that will be necessary during the SAR process and at the conclusion of the SAR, ensuring that a communication strategy is in place, with clear leadership and co-ordination.
- Agree the final product that will be produced and how it will be presented to the SSAB
- Propose how any learning from the SAR should be implemented
- Propose how the SAR should be published, taking account of factors that may emerge throughout the process

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The "Senior Accountable Officer" is an organisations most senior manager (e.g. Chief Executive)

- Agreeing how the Independent Chair raises any issues that arise as part of the process and with who

8.6 All agencies represented on the SSAB, must be aware of the criteria for implementing a SAR as set out above. The SSAB members commit to their agency being involved in any SAR if their professional role can add value to the process. Safeguarding arrangements as required under the Care Act 2014 do require agencies to co-operate.

## 9. INVOLVING THE PERSON, THEIR FAMILY AND/OR RELATIVES

9.1 Involving the adult at risk (if they have survived) and/or their family are significant to the SAR process. The purpose of a SAR and the process it follows will be unfamiliar for the 'adult at risk' and/or their family, adding to their distress and inevitable concerns. It will be a very sensitive time for everyone and consideration should be given at an early stage as to how this will be done; the on-going identified support to those involved (how and who will provide it) with timely discussions taking place with the family or adult at risk, as to how the process will work, how they want to be involved and the type of outcomes that are likely from a SAR in general.

9.2 If the relative(s) to be involved is considered an 'adult at risk', consideration must be given to the support they require in terms of a representative or advocate.

9.3 Specific consideration should be given as to how to involve the 'adult at risk' who is subject to SAR process (if they have survived) so they are as involved in the process as far as they want to be. If the 'adult at risk' has capacity to consent, and allows for family (or friends) to be involved in the SAR, they will be invited to contribute their views. However, they should be made aware that a SAR is not about apportioning blame but is a review of agency functioning through which people are encouraged to reflect critically about their practice which translates into change and improved practice and working.

9.4 The 'adult at risk' may need a worker and/or advocate supporting them through the process; where relevant, appropriate communication with the worker and/or advocate will need to be considered. This will include informing them of the SAR and, if they are not SAR Panel members, sharing the outcomes in a way they wish for them to be shared.

9.5 There should be clear consideration given at the outset as to any specific inputs that the family, relatives or the person who is the focus of the SAR should make or are encouraged to make (for example shaping the Terms of Reference or how the person who is subject of the SAR is referred to in any report).

9.6 Throughout the whole process due diligence, compassion and appropriate support must be provided the Local Authority or an alternative should be arranged if that is more appropriate. What type of support the individual is required and who will provide it will be determine by the Independent SAR Panel Chair in conjunction with the Quality and Performance Subgroup.

## 10. SUPPORTING STAFF AND OTHERS INVOLVED IN THE SAFEGUARDING ADULT REVIEW PROCESS

10.1 As soon as a SAR has been agreed, staff and others that have had involvement in the case should be notified of this decision by their agency, as well as the role they wish their staff to play in the review. The nature, scope and timescale of the SAR should be made clear at the earliest possible stage to staff, others and their line managers. It should be made clear that the review process can be lengthy.

10.2 Enabling and supporting staff who have been involved in a case that is subject of a SAR and to encourage them to share their views on the case as appropriate, is a key to the agency reviewing their organisational involvement and collating the required information. It enables the best way possible to determine information about the situation and circumstances of the case in question, enables a much richer review of the agency's involvement and ensures staff feel involved and therefore more able to implement recommendations and actions that subsequently follow.

10.3 All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so real learning and improvement can happen.

10.4 Agencies are responsible for ensuring their own staff, volunteers and others are provided with a safe environment to discuss their feelings and offered support where and as needed. The death or serious injury of an adult at risk will have an impact on staff and others and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

10.5 At the conclusion of the SAR each agency should consider the best way to involve staff and others in disseminating learning that has been identified, and to ensure oversight of practice that subsequently changes. It is also important to note that staff who may not have been directly involved in an issue that becomes a SAR may well have learning to consolidate from a SAR's outcome. This equally applies to the agency who may not also not have been directly involved but where disseminated learning is still required.

## 11. PROFESSIONAL CONDUCT ISSUES

11.1 This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

11.2 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR panel to deal with these.

11.3 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.

## 12. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

12.1 There will always be a final report with recommendations arising from a SAR. The complexity and proportionality of the report will match the issues in question.

12.2 The Chair SAR Panel must ensure that there is sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process. 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, to be produced by the nominated author.

12.3 The final report should always be produced as soon as is practical at the conclusion of the SAR process. The SAR panel should receive and agree the draft report before it is presented so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented. However, it should be understood that the Chair of the SAR Panel is the person that should have final editorial oversight of the final report. If there are issues arising that are contentious, and full agreement to the final report is an issue, then the Chair of the Quality and Performance Subgroup should be engaged to enable an appropriate way forward.

12.4 Final reports (including an Executive Summary, recommendations and any agency action plans) will be presented to the Quality and Performance Subgroup ahead of any SSAB meeting, to consider the issues and resulting recommendations seeking clarification on any issues as required. Any outstanding issues or resolution will be confirmed. The final agreed report, with a resulting Composite Action (developed by the Quality and Performance Subgroup) will then be presented to the next SSAB meeting.

12.5 A sample report template is provided in Appendix 7.

## 13. PUBLISHING REPORTS

13.1 The SSAB recognises collective responsibility, open and transparent governance and the need for evolved learning. However, considerations of reputational risk or national learning arising from the case may affect decisions as to how the report is published. The SSAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could be publication via the SSAB webpage. Agencies and SSAB members can provide the relevant links to the SAR report as required. This will be kept under review.

13.2 The chair of the SSAB will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with prevailing Information Sharing Agreements, the Data Protection Act, Information Governance arrangement and other legal requirements.

13.3 The Care Act 2014 requires the SSAB to publish the findings of any SAR in its annual report, recognising the interests, transparency and disseminating learning but doing so within the legal parameters of confidentiality, setting out how learning will be implemented. Where the SSAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

13.4 Any reports to be published must be fully anonymised. However, in doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised nomenclature.

## 14. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

14.1 The real value of a SAR is to ensure that the relevant lessons, specific or wider learning, are understood, the impact considered, addressed and consolidated into improved working arrangements within and across all services supporting adults at risk and that multi-agency safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

14.2 The Quality and Performance Subgroup will be responsible for ensuring the development of a Composite Action Plan (see Appendix 8) to ensure identified report recommendations are fully set out, prior to presentation to the SSAB.

14.3 Once a report and its recommendations have been confirmed by the SSAB the Subgroup will retain oversight of implementation of the recommendations, with updates to the SSAB as necessary. Agencies (either directly involved, or those who will benefit from the wider learning) will need to ensure actions are implemented updating the Subgroup on progress/achievement so the Composite Action Plan is effectively monitored.

14.4 In addition to SARs that are conducted by the SSAB, it will be as important to learn from SARs conducted by other SSAB areas more generally, but especially where they relate to a Southwark person whose services have been commissioned in another local authority area, or where any Southwark provider or agency is involved. This is to ensure that the Southwark SSAB does everything possible to prevent similar issues occurring in its area.

## 15. SUPPORTING AND RESOURCING SAFEGUARDING ADULT REVIEWS

15.1 It should be noted that SAR process will present a range of resource requirements, both in terms of immediate capacity and budget to appropriately service the process.

15.2 The SSAB has to take a lead role in supporting the SAR process, supporting the setting up of the SAR Panel and supporting the Quality and Performance Subgroup in ensuring the right resources are made available to respond to this statutory requirement. This could include, but not limited to, budget to hire an independent chair or facilitator, additional capacity to facilitate all necessary actions, reports and writing of the report and support to relatives or people at the focus of the SAR in terms of advocacy or personal representatives.

15.3 Whilst recognising the challenges that all agencies are under in terms of resource constraints, this cannot impede the delivery of this statutory requirement.

# 16. SUMMARY OF SAR PANEL, SUBGROUP RESPONSIBILITIES AND SSAB

## Responsibilities of the Safeguarding Adult Review Panel

16.1 In addition to the more detailed issues set out within this Protocol, the SAR Panel will have specific responsibility for agreed activity and actions.

16.2 The SAR Panel, under the leadership of the Independent Panel Chair, will lead the review of the circumstances and issues surrounding the case referred for SAR, using whatever methodology as agreed.

16.3 The SAR Panel is made up of a minimum of a nominated Chair, supported by the Southwark Safeguarding Adults Board Manager (or agreed alternative) representing the Quality and Performance Subgroup and key individuals who have been invited to be involved. As minimum, statutory agencies such as the local authority, police and health commissioners (CCG) will be involved.

16.4 The SAR Panel will clearly set agreed terms of reference, clear process and direction for gathering information, as well as collate and review information.

16.5 The final product will be an Overview Report, including recommendations, accompanied by an Executive Summary as well as any specific action plans from contributory organisations.

16.6 Throughout this process the SAR Panel will consider communication matters and communication strategy, linking with the Quality and Performance Subgroup as required. Where legal opinion or guidance is required this should be provided by the Council Legal Services, and will be accessed via the linked representative of the Subgroup sitting on the SAR Panel.

16.7 The SAR Panel's work should be completed within 6 months of the initial decision to commission a SAR. Agency improvements should commence as soon as they have been identified (e.g. prior to or during the earlier stages of the Review).

## Responsibilities of the Quality and Performance Subgroup

17.8 The Quality and Performance Subgroup has delegated responsibility from the SSAB to have oversight of all SAR activity, policy and process. When a SAR has been commissioned, the Quality and Performance Subgroup, under the leadership of the Subgroup Chair (or nominated representative) acts as a liaison to the SAR panel and will arbitrate on any issues or decisions the SAR Panel and Independent Chair identify or raise.

16.9 The Subgroup acts as the intermediary between any SAR Panel and the SSAB, and supports the work of the Panel in whatever way is appropriate either as a collective group or through delegated tasks to assigned members or assigned representatives

16.10 The Quality and Performance Subgroup will work with the SSAB and SAR Panel to identify any conflict of interests are identified and addressed (e.g. a Quality and Performance Subgroup agency representative may also be required to produce an IMR for the Panel). Mitigating actions will be put in place and monitored so the best possible evidence is collated and review appropriately.

16.11 Throughout the process the Subgroup, via the Chair, should monitor the progress of the SAR via updates from the independent Chair/report writer.

16.12 The Final Overview Report, Executive Summary and recommendations will be presented to the Subgroup to enable supportive presentation to the SSAB. The Subgroup will ensure that there is a relevant Composite Action Plan, turning recommendations into actions and that this accompanies any documentation to be presented to the SSAB.

16.13 The Subgroup will inform the SSAB Chair that the review has been concluded and the report is available. Arrangements will be made for the Overview Report to be presented to a SSAB meeting, so it can approve of the Report.

## Responsibilities of the SSAB

16.14 Ultimate responsibility for the completion of an agreed SAR, the related recommendations and their implementation remains with the SSAB. They are also required to lead on communication issues and ultimate publishing arrangements. In practice the Quality and Performance Subgroup undertakes most of this as the delegated group, but accountability remains with the SSAB.

16.15 The SSAB will formally approve the Overview Report and formally accept the review findings and recommendations as appropriate. Any recommended final revisions should be referred back to the SAR Panel for their action.

16.16 An Executive Summary will be produced to share the learning from the SAR. The SSAB will need to confirm how and if the report is made public, the form of this and any following communication or media management.

**Southwark Safeguarding Adults Board**

# LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

# APPENDICES AND TOOLS

**(Note: The following includes a selection of sample tools that can be used in helping SAR Panel and are produced for simplicity and to enable clarity of relevant process)**

# APPENDICES

## APPENDIX 1

**Making a Safeguarding Adult Review referral**

**Form A: Referral Notice**

## APPENDIX 2

**Sample templates for completing any Individual Management Review and Chronology**

**Form C: IMR SUMMARY AND IDENTIFYING INFORMATION**

**Form D: IMR CHRONOLOGY OF AGENCY INVOLVEMENT**

**Form E: IMR LIST OF SUPPORTING DOCUMENTS**

**Form F: IMR ANALYSIS OF INVOLVEMENT**

**Form G: IMR LEARNING**

**Form H: IMR OVERALL SUMMARY AND CONCLUSIONS AS A RESULT OF YOUR REVIEW**

**Form J: RECOMMENDATIONS FOR YOUR AGENCY ARISING FROM YOUR REVIEW OF THIS CASE**

**Form K: SIGN OFF - AGENCY OWNERSHIP OF INDIVIDUAL MANAGEMENT REVIEW**

## APPENDIX 3

**Guidance for Conducting Interviews**

## APPENDIX 4

**Template Letter A – Initial Notice of SAR**

**Template Letter B – Initial Independent Chair Letter setting out the process (letter can be adapted):**

## APPENDIX 5

**Roles**

## APPENDIX 6

**Safeguarding Adult Review – Considerations for Terms of Reference**

## APPENDIX 7

**Sample template for Completing Report (with prompts)**

## APPENDIX 8

**Sample Composite Action Plan**

## APPENDIX 9

**Useful information**

# APPENDIX 1:

## Making a Safeguarding Adult Review referral and deciding if the referral should be subject to a Safeguarding Adult Review

The format for requesting a Safeguarding Adult Review is set out in **Form A (Parts 1 and 2).** The completed request must be sent in the first instance, under confidential cover to SSAB@Southwark.gov.uk or at the address below.

Part 1 – requires demographic information and a summary of the issues that met the SAR criteria

Part 2 - Offers questions as a guide to help decide whether or not a case could be subject to a Safeguarding Adult review. The answer "yes" or "maybe" to several of these questions is likely to indicate that a review may yield useful lessons. The decision to request a SAR should be made by someone of appropriate seniority within the organisation.

Please do not copy and paste information from other forms, unless it is fully explained and all required detail completed.

**Email to:** SSAB@Southwark.gov.uk

**By Post to:**

**Southwark Safeguarding Adult Board**
PO Box 64529
London
SE1P 5LX
All requests will be assessed by the SSAB Quality and Performance Subgroup in accordance with this SAR Protocol.

**Content of the request:**

1. Name of the person submitting the request for a Safeguarding Adult Review.

2. Position/designation of person making the request.

3. Agency/organisation of the person making the request (if applicable).

4. Contact details, to include address, telephone number, fax and e-mail.

5. Brief details of the issue to include:

- The name(s) and date of birth of the victim(s) (if known)
- Name of any service provider involved
- Local authority involved in the safeguarding adults case
- Name of the Safeguarding Adults Co-ordinating Manager and or the Chair of any strategy meeting or safeguarding adults case conference (if known)

- Details of why, in the referrer's opinion, the case meets the Safeguarding Adult Review criteria and guidelines contained in paragraph 3 of the protocol, specifically linking the referred to the criteria

**Please note that the report should not exceed 3 sides of A4 paper for form A. If any additional information is required you will be contacted.**

# Form A: PART 1- REFERRAL NOTICE

| REFERRAL INFORMATION | |
|---|---|
| **Name (of person making a referral):** | |
| **Name of your Agency** | |
| **Position:** | |
| **Your email:** | |
| **Your address:** | |
| **Your telephone number:** | |

| IDENTIFYING INFORMATION | |
|---|---|
| **Name of person(s) being referred:** | |
| **Date of birth(s)** | |
| **Date of incident or issues (please give time range if more appropriate)** | |

| SUBMISSION DETAILS | |
|---|---|
| **Email to**<br>SSAB@Southwark.gov.uk | **By Post to:**<br>**Chair of Southwark Safeguarding Adults Board**<br>PO Box 64529<br>London<br>SE1P 5LX |

| **REASON FOR REFERRAL**<br><br>**(Do not exceed 3 sides of text)** |
|---|
| *When considering a case for a SAR, more formal process are likely to be reserved where there is multiple agency involvement and subsequent failure or significant public interest.*<br><br>*Please refer to Section 4 of the Protocol for more assistance in defining a SAR* |
| **Why are you referring this case for Safeguarding Adult Review?** In making your referral for Safeguarding Adult Review, you should consult the local policy, setting out your reasons as to why the criteria is met. The criteria you should consider are:<br><br>1. *"An SSAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if,*<br>*(a) there is reasonable cause for concern about how the SSAB, members of it or other persons with relevant functions worked together to safeguard the adult, and*<br>*(b) condition 1 or 2 is met.*<br><br>2. *Condition 1 is met if:*<br>*(a) the adult has died, and*<br>*(b) the SSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*<br><br>3. *Condition 2 is met if:*<br>*(a) the adult is still alive, and*<br>*(b) the SSAB knows or suspects that the adult has experienced serious abuse or neglect.*<br><br>**Please include, details of any safeguarding meetings held, and names of Social Workers or Safeguarding Adults Managers or others involved in the case.** |
| [insert your summary here of the case and why SAR criteria is met] |

| | |
|---|---|
| **Completed by** | |
| **Signed** | |
| **Name (Please print)** | |
| **Date** | |

# Form A: PART 2 – PROMPTS TO HELP DECIDE IF A REFERRAL SHOULD BE CONSIDERED FOR SAFEGUARDING ADULT REVIEW

| **Question or consideration** *(NB These are prompts and not an exhaustive list and further issues can be added)* | **Yes/No/ Maybe** | **Any comments or notes** |
|---|---|---|
| Is there clear evidence of significant risk or harm that was not recognised by organisations or individuals in contact with the adult at risk or the perpetrator? | | |
| Is there clear evidence of significant risk or harm that was not shared with others? | | |
| Is there clear evidence of significant risk or harm that was not acted on appropriately? | | |
| Did a family member cause the serious injury or death? | | |
| Was the adult at risk abused in an institutional setting? | | |
| Do one or more agencies consider that its concerns were not taken sufficiently seriously or acted on appropriately by another agency? | | |
| Was the adult at risk subject to a protection plan or subject previously been the subject of a safeguarding adults investigation? | | |
| Does the case have implications for a range of agencies and/or professionals? | | |
| Does the case suggest that the SSAB may need to change its protocols or procedures, or that policy and procedures are not being properly used, understood or acted upon? | | |
| Is there likely to be significant public interest? | | |

# APPENDIX 2:

## Template forms for completing an Individual Management Review and Chronology

**Introduction**

The following (Forms C to K [note there in no 'Form I') are a set of templates that combined as a set form an Individual Management Review (IMR). This details an agency's involvement and sets out their relationship to the person(s) under consideration.

- These templates are to be fully completed by each agency who has been involved with the person(s) subject to the SAR, and who has been asked to do so by the SAR Panel. They record the decisions, actions taken and services provided to the person(s) who is subject of a Safeguarding Adult Review.

- The aim of the IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

- The findings from the IMR report should be endorsed by the Senior Responsible Officer within the organisation who has commissioned the IMR and who will be responsible for ensuring that recommendations are acted upon.

- The IMR provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement with that agency

All Individual Management Reviews will be in **Arial** and **Font 12.**

The completed IMR should be returned to Please return to SSAB@Southwark.gov.uk or to the address above

## IMR SECTION 1

## Form C: IMR SUMMARY AND IDENTIFYING INFORMATION

| | |
|---|---|
| **Name of Agency** | |
| **Name of Lead Person Completing IMR and Chronology:** | |
| **Address:** | |
| **Contact Telephone Number:** | |
| **Email:** | |
| **Name Of Adult(s) at risk of harm:** | |
| **Date when your involvement with the adult at risk started:** | |
| **Date when your involvement with the adult at risk started ceased:** | |
| **Factual summary of agency involvement:**<br>Provide a brief factual and contextual summary of your agency's involvement with the adult for the time period identified for this Safeguarding Adult review | |
| | |

# IMR SECTION 2

## Form D: IMR CHRONOLOGY OF AGENCY INVOLVEMENT

**Notes:** What was your agency's involvement with this adult at risk? Construct a comprehensive chronology of involvement of your agency and/or professional(s) in contact with the adult at risk over the period of time set out in the review's terms of reference. The information which is required under each heading should be fairly self-explanatory. The last column "comment" should be used if the agency reviewer wishes to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue.

It is important that you insert the date to facilitate merging with chronologies from other agencies and that nothing else is entered in the date column. Where abbreviations are used, please provide a glossary at the back of this document to explain them**.**

| | |
|---|---|
| **Name of agency:** | |
| **Name(s) of adult(s) at risk:** | |
| **Ethnic origin:** | |
| **Dates covered by the chronology:** | |

| Date | Source of Evidence | Contact with (initials) | Name of professional | Communication/reason /incident/contact location | Actions taken/ decisions made | Comment |
|---|---|---|---|---|---|---|
| dd/mm/yy | | | | | | |
| dd/mm/yy | | | | | | |
| dd/mm/yy | | | | | | |
| dd/mm/yy | | | | | | |

## IMR SECTION 3

## Form E: IMR LIST OF SUPPORTING DOCUMENTS

**Notes:** Please list all source documents you have used in completing your Individual Management Review.

| Document | Reason/Commentary/Link or Reference |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# IMR SECTION 4

## Form F: IMR ANALYSIS OF INVOLVEMENT

**Notes:** The agency is expected to rigorously analyse their involvement, with their designated report writer capturing this information. Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Please use the template provided, and if one section does not apply to your agency then identify that this is the case in the appropriate box.

Facts should not be stated without their origin and related evidence and any source material should be referenced on Form E.

Consider specifically the following areas (each box is designed as a prompt to add specific information, and will expand as you type):

| | |
|---|---|
| **1** | **SUMMARY:** Summarise your analysis of the involvement of your agency with this adult at risk. |
| | |
| **2** | **POLICY & PROCEDURE:** Did your agency have in place policies and procedures for safeguarding adults? Please indicate when these policies were last reviewed. |
| | |
| **3** | **STAFF KNOWLEDGE & AWARENESS - GENERAL AND SPECIFIC:** Were all practitioners and managers sensitive to the needs of the adults 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? Provide evidence. |
| | |

| | |
|---|---|
| | |
| **4** | **CARE AND SUPPORT PLANNING:** Was there a clear plan of care for the adult(s) at risk? Did all your practitioners and managers involved in the care and management accord with care arrangements you were required to provide? What is your evidence? |
| | |
| **5** | **PROFESSIONAL STANDARDS:** Did all of your practitioners and managers actions and practices accord with the standards of care that were required to provide, whether that be as per your organisational policy and expectations and/or in accordance with formal professional standards to which their role relates? |
| | |
| **6** | **SERVICES PROVIDED:** Were all appropriate services offered and/or provided. Were relevant enquiries made, where necessary in the light of assessments? Evidence |
| | |
| **7** | **ASSESSMENT AND DECISION MAKING:** What were the key relevant points and opportunities for assessment and decision making in relation to this particular adult at risk? Is there evidence that assessments and decisions have been reached in an informed and professional way? |
| | |
| **8** | **SPECIFIC SAFEGUARDING ARRANGEMENTS:** Where relevant, were appropriate safeguarding adults or care plans in place, and safeguarding adults reviewing processes complied with? Evidence |
| | |

| | |
|---|---|
| | |
| **9** | **CAPACITY:** Was a Mental Capacity Assessment of the adult at risk completed with regards to any relevant decision he/she needed to make? Was this information recorded? Evidence |
| | |
| **10** | **SENIOR OVERSIGHT AND SCRUTINY:** Were more senior managers in your organisation and/or were other agencies and professionals, appropriately involved at points where they should have been? Did your staff escalate any issues of concern, raise matters of concern with other professionals or seek guidance where necessary? EVIDENCE |
| | |
| **11** | **PROCESS AND ACTIONS:** Are you satisfied that all the care provided to the individual was satisfactory? After the person had died (if relevant), are you satisfied that all appropriate actions, process and investigations were undertaken to fully determine if the care of the individual had contributed to their death? |
| | |
| **12** | **EQUALITY AND CULTURAL SENSIVITY:** Was the practice of all people involved in the care of the adult(s) at risk from your agency sensitive to the racial, cultural, linguistic and religious identity of the person? |
| | |
| **13** | **ADDITIONAL FACTORS:** Are there any particular features of this case, or issues surrounding the death or injury of the person, that you consider require further comment in respect of your agency's involvement. |

## IMR SECTION 5

## Form G: IMR LEARNING

This section is for you to critically review the case from your perspective and consider any learning from your agency's perspective or wider learning that the SAR panel could consider. The form will expand as you type

| | |
|---|---|
| **1** | Are there **lessons** from this case for the way in which your agency works to appropriately support adults at risk and/or safeguard them? |
| | |
| **2** | Is there **good practice** to highlight, as well as ways in which practice can be improved? |
| | |
| **3** | Are there **implications** for ways of working within your agency? |
| | |
| **4** | Are there implications for **training** (single or multi-agency)? |
| | |

| | |
|---|---|
| **5** | Are there implications for the **management of staff** within your agency and/or supervision of staff who work for your agency? |
| | |
| **6** | Are there implications for **working** with other organisations? |
| | |
| **7** | Are there implications for **service provision** within your organisation? |
| | |
| **8** | Are there any **other issues**, implications or remedial actions for your agency? |
| | |

## IMR SECTION 6

## Form H: IMR OVERALL SUMMARY AND CONCLUSIONS AS A RESULT OF YOUR REVIEW

| 1 | Please provide an overall summary of your review |
|---|---|
| | |

# IMR SECTION 7

## RECOMMENDATIONS FOR YOUR AGENCY ARISING FROM YOUR REVIEW OF THIS CASE

**Notes:** Based upon your review and conclusions please set out the recommendations that you propose for your agency. These should be focused, specific, measurable and capable of being implemented. A view on how these could be achieved should be included. Consideration should be given to the resources required to implementing the recommendations.

Recommendations should be divided into:

**Review** – changed practice that should already be happening (if this has been a previous recommendation include an analysis of why previous actions have failed)

**New** – actions that need to be introduced and implemented as a result of your review.

Recommendations should be also be identified as either (i) **Multi-agency and/or** (ii) **Single agency.**

## Form J: RECOMMENDATIONS FOR YOUR AGENCY ARISING FROM YOUR REVIEW OF THIS CASE

**Recommendation**: *Insert here your recommendation*

| a<br>Agency(s) | b<br>Lead Professional | c<br>Action (required or taken) | d<br>Timescale | e<br>Barrier to implementation | f<br>Outcome of recommendation | g<br>Progress |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Recommendation**: *Insert here your recommendation*

| a<br>Agency(s) | b<br>Lead Professional | c<br>Action (required or taken) | d<br>Timescale | e<br>Barrier to implementation | f<br>Outcome of recommendation | g<br>Progress |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Insert more recommendation tables as needed by cutting and pasting.

Guidelines for completing Safeguarding Adult review action plans. Each agency to identify a lead professional to co-ordinate their agency response and name to be forwarded be included and details provided

a. Name of **agency**

b. In the **lead professional** column clearly identify name and role of person.

c. In the **action** column indicate what action has been taken to address the recommendation or what action will be taken.

d. In the **timescale** column provide the date action was completed and/or provide a realistic timescale for your agency in which to address outstanding action.

e. In the **barrier to implementation** column identify any barriers to taking the action forward in your agency.

f. In the **outcome of recommendation** column provide a summary of the impact of the recommendation, how the agency has learnt lessons and identify source of evidence to demonstrate learning.

g. In the **progress** column state whether action arising from the recommendation is ‘compliant’ ‘progressing’ or ‘non-compliant’.

## SECTION 9

## Form K: SIGN OFF - AGENCY OWNERSHIP OF INDIVIDUAL MANAGEMENT REVIEW

| | |
|---|---|
| **IMR completed by:** | |
| **Name:** | |
| **Position:** | |
| **Signature:** | |
| **Date:** | |

***The undersigned person is the most senior person within your agency who agrees with the IMR as detailed and the recommendations to be taken***

| | |
|---|---|
| **IMR Agreed by:** | |
| **Name:** | |
| **Position:** | |
| **Signature:** | |
| **Date:** | |

***Once completed the IMR should be submitted to the Safeguarding Adult Review SAR Panel. If the IMR is not felt to be of a sufficient standard it may be returned identifying additional work required. The Independent Overview Report author is expected to comment upon the quality of the IMR and the analysis contained and will provide feedback which may require the IMR to be amended or reviewed.***

# APPENDIX 3

## Guidance for Conducting Interviews

It is suggested that it may be helpful for the IMR writer to use the following format when conducting interviews in the process of compiling the IMR report:

***Details of Contributor***
*Full name:*
*Qualifications:*
*Designation:*
*Time in post:*
*Employing Body:*
*Employing Address*
*Home Address: (where appropriate)*
*Previous Employment:*
*Employer Dates & Posts held:*
*Description of role in relation to particular case:*

**Matters to be covered in interviews**

This is to be used in conjunction with the chronology of the case to check facts, discuss the interviewee's specific participation and the time scale of their involvement.

Explore with the interviewee:

**(a)** Their knowledge of the history of the case and the adult at risk(s) prior to the interviewee's involvement;

**(b)** Their specific involvement in the case;

**(c)** Their knowledge of their employing agency's policy and procedures in relation to Social Care and Safeguarding Adults;

**(d)** Their knowledge of identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon adults at risk, Service User engagement techniques and their role in relation to Safeguarding Adults meetings;

**(e)** The methods used to relate to and communicate with other professionals in the case;

**(f)** The interviewee's record keeping;

**(g)** The supervision received by the interviewee

**(h)** The interviewee's feelings about the case, the adult at risk and/or the adult at risk's carer and how those feelings were dealt with in supervision;

**(i)** The range of training both internal and external the interviewee has attended within the last 2 years;

**(j)** Looking back, what the interviewee would do differently now;

**(k)** What lessons the interviewee learnt from the case;

**(l)** What the interviewee believes the agency could/should learn from the case.

# APPENDIX 4

## Template Letters

## Template Letter A – Initial Notice of SAR:

Dear [insert name]

**NOTICE OF SAFEGUARDING ADULT REVIEW**

***Insert name of adult at risk***
**Date of Birth:**
**Date of Death:**

A decision has been made that the above named person is to be made subject of a Safeguarding Adult Review.

On behalf of the Chair of the Southwark Safeguarding Adults' Board, I am writing to formally request that you take action to ensure that your agency files in respect of this person are immediately secured to guard against potential loss or interference, and to enable the Safeguarding Adult Review process to commence.

A Safeguarding Adult Review (SAR) Panel will be convened shortly to agree the Terms of Reference of the Safeguarding Adult Review and the focus of the Independent Management Review. Once these issues have been resolved we will communicate with you again on the next steps.

Please can you contact me by return with the name of the lead contact in your organisation with which the SAR Panel Independent Chair should make contact with.

If you have any further questions please contact the Head of Safeguarding on 020 8487 5369 or by email:

Yours sincerely,

**Chair, Quality and Performance Subgroup of Southwark's Safeguarding Adult Board**

## Template Letter B – Initial Independent Chair Letter setting out the process (letter can be adapted):

Dear

**Re: Safeguarding Adult Review in relation to: xxxx**

**Date of Birth: xxxx**

You were recently contacted by the Southwark Safeguarding Adults Board regarding a Safeguarding Adult Review relating to the above named person.

I have now been appointed as Independent Chair of this Safeguarding Adult Review and as such I am writing to request that your agency participate in the SAR Panel that is being established. Your name has been given as the point of contact for your agency.

I would emphasise that the purpose of this Safeguarding Adult Review is not to apportion blame but to establish whether there are any issues in relation to inter-agency working under the Pan London Policy and Procedures for Safeguarding Adults at Risk, and to identify in the review process between the agencies in the SAR Panel, any lessons to be learned. It is my intention to ensure that the SAR process is clearly focused encouraging a good exchange of information and a constructive dialogue and outcome.

My intention is that the initial SAR Panel will have its first meeting in the week beginning xxxx. At this meeting we will confirm the Terms of Reference of the Panel and agree the process for gather of Individual Management Reviews (IMRs). This will inform a final Overview Report, which will be presented to the Safeguarding Adults Board together with a draft Action Plan to address any recommendations that the SAR Panel may make.

I look forward to working with you. Do feel free to contact me by [insert contact details] f you would like to discuss this further.

Yours sincerely,

**Safeguarding Adult Review Independent Chair**

# APPENDIX 5

## Roles

**Chair of SSAB**

- Retain strategy oversight of an SAR process
- Support the SSAB to fully consider the merits of a referral
- Assist in arbitrating issues that are problematic; enable the SSAB to understand the findings of an SAR

**Chair of SSAB Subgroup**

- Receive referral
- Arrange Subgroup consideration
- Refer to the SSAB
- Act as intermediary between SAR panel and SSAB
- Senior point of reference for SAR panel oversight
- Strategic Composite Action Plan

- Enable practical delivery of SAR Panel process
- Practical point of reference

**Independent Chair SAR Panel**

- Lead overview of SAR review
- Link to relevant agencies
- Write SAR report
- Propose SAR Composite Action Plan
- Present to SSAB

# APPENDIX 6

## Safeguarding Adult Review – Considerations for Terms of Reference

Any SAR has been convened in accordance with the Board's Procedure and Guidance for Conducting Safeguarding Adult Reviews, as it is deemed to the criteria.

The Terms of Reference for a SAR will be specific to the circumstances of each individual case but should consider:

- The 6 Principles of Safeguarding (see para 14.4 *Care and Support Statutory Guidance (issued under the Care Act 2014)*
- The care arrangements in place for the individual
- If any of the care or support contributed in any way whatsoever to the individuals' death or their significant harm.
- If all appropriate practices and professional standards were followed by staff assigned to the individual's care.
- If there was sufficient co-ordination amongst all agencies involved
- Any learning from this situation and make recommendations to improve future working practices

## APPENDIX 7

*The following is a template that can be used for a SAR Report.*

*The prompts set out in the pages that follow in bullet form are no more than ideas and issues to be covered (if appropriate) but are not exhaustive and open for additions as required*

# SOUTHWARK
# SAFEGUARDING ADULTS BOARD

# SAFEGUARDING ADULTS OVERVIEW REPORT

| | |
|---|---|
| **Name of adult at risk** | |
| **Date of birth** | |
| **Date of death** | |
| **Age at time of incident** | |

## 1. Executive Summary

- *An overall high level standalone summary of the case and issues in question*

## 2. Introduction

*Prompts*

- *Give a summary of the aims of the report and the individual who is the subject of the review.*
- *Clarify that the SAR has been conducted as either a statutory review under Section 44 of the Care Act, or as a non-statutory SAR as agreed by the SSAB. Set out that this SAR has been undertaken in line with the London Multi-Agency Safeguarding Adults Policy and Procedures and with Southwark' SSAB's SAR Protocol.*
- *Clarify that the SAR is not intended to reinvestigate the case or apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimate improve the safeguarding and wellbeing of adults in the future.*

## 3. The circumstances that led to a SAR being undertaken in this case.

*Prompts*

- *Provide a brief and anonymous overview of the specific individual circumstances that led to a SAR being undertaken for this case.*
- *Provide reasons for conducting the review and what SAR criteria were met (or if the criteria were not met the reason for conducting the review).*
- *State decision and date to hold the SAR.*

## 4. Terms of Reference

*Prompts*

- *State when the SAR commenced, details of the commissioner (usually independent chair of SAP), SAR panel members, and the report author.)*
- *State the dates the SAR panel met and the agreed terms of reference for the SAR.*
- *List contributors to the review and the nature of their contributions (e.g. management report by social care, serious incident report from health agency, interview with staff members, etc.)*
- *Cite contribution of family members and any others. Include any communication with CQC or Government Office. Set out how the involvement of staff and the adult/ family/ friends/ carers was facilitated and supported (e.g. advocacy).*
- *Identify the key issues within the SAR. Comment upon the quality of the evidence supplied and whether any action was required. Provide an explanation for any delay in completing the SAR in relation to the SAR framework and terms of reference.*

## 5. Case summary: The Facts

*Prompts*

- *Provide a brief case summary including details of the incident, kind of maltreatment, who was believed responsible for the abuse. This should include:*
    - *A pictorial display of the adult at risk's relationship to family members (if this adds benefit), extended family and household and any care services provided. Details provided should be brief and anonymous (as appropriate).*
    - *An integrated chronology, timeline or narrative of agency involvement with the adult at risk, family/ carer on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology/ narrative each occasion on which the adult at risk was seen and the adult at risk's views and wishes sought or expressed.*
    - *An overview that summarises what relevant information was known to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult at risk.*

## 6. Analysis or Report of Findings

*Prompts*

- *Look at how and why events occurred, decisions were made and actions taken or not taken.*
- *Explain how events and conditions had looked to professionals at the time of the incident and in the period leading up to it.*
- *Explore the range of contributory factors and systems conditions that played a part in causing the abuse or neglect.*
- *Consider whether different decisions or actions may have led to an alternative course of events.*
- *Consider how system conditions would have needed to be different to facilitate the different actions or decisions that would have been required.*
- *Highlight any examples of good practice.*
- *Analysis of the collated information in general and specific*

## 7. Conclusions and recommendations

*Prompts*

- *Summarise, in the opinion of the SAR Panel, what the key themes and patterns in the system arising from the SAR are and what lessons can be drawn from the case.*
- *Translate the lessons into recommendations for areas Southwark SSAB should address to improve working and outcomes for adult at risk at their families.*
- *Recommendations should be few in number, focused and specific, and capable of being translated into an achievable action plan. Views on how the recommendations can be*

*translated into action can be included. Consideration should be given to the resources required to implement the recommendations such as cost.*

- *Recommendations should be divided into:*
- *Review – practice that should already be happening*
- *New – actions that need to be introduced and implemented.*
- *If there are lessons for national, as well as local, policy and practice these should also be highlighted.*

## 8. Proposed multi-agency action plan

- *The author and SAR panel may provide a proposed set of actions for discussion, adaption and approval by the SSAB.*
- *The action plans should support the implementation of the recommendations identified in section 6 of the report.*
- *The actions identified should be multi-agency in nature: requiring the combined action of a number of partners in order to achieve them.*
- *Some single-agency actions may be identified where these are vital to the implementation of the recommendations.*
- *The action plan should conclude with a statement on how the plan will be reviewed to determine if the outcomes have been achieved.*

## APPENDIX 8

## SAFEGUARDING ADULT REVIEW: COMPOSITE ACTION PLAN [INSERT NAME]

| RECOMMENDATION | ADDITIONAL COMMENTS OF POINTS OF CLARIFICATION | ASSIGNED LEAD AGENCY AND LEAD OFFICER | UPDATE ON PROGRESS/ COMMENTARY | DATE WHEN COMPLETED |
|---|---|---|---|---|
| **RECOMMENDATION 1:**<br><br>*Write in here the specific recommendation from the SAR Panel exactly as worded, adding further rows as required* | *Add in here any additional comments of points of clarification that enable the reader to be clear what is required* | | *This is the 'live' commentary and update of progress that shows the reader (and Quality and Performance Subgroup) progress against the recommendation* | |
| **RECOMMENDATION 2:** | | | | |
| **RECOMMENDATION 2:** | | | | |

# APPENDIX 9 - USEFUL INFORMATION

***Care and Support Statutory Guidance October 2016 (issued under the Care Act 2014)***

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

**Learning Together (Social Care Institute of Excellence)**

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

## Acknowledgements

Southwark Safeguarding Adult Board would like to thank, acknowledge and recognise the work of the London Borough of Richmond upon Thames Safeguarding Adults Board SAR Subgroup which formed the template on which this protocol is based. Southwark Safeguarding Adult Board is grateful for the permission Richmond granted to use the materials in their local protocol.