Portsmouth Safeguarding Adults Board

Safeguarding Adults Review (SAR) Policy

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Contents

Introduction

Section 44 of the Care Act 2014 places a duty on Safeguarding Adults Boards (SABs) to arrange Safeguarding Adults Reviews (SARs) in certain circumstances. Further information on SARs is set out in the Care and Support Statutory Guidance (paragraph 14.162 onwards). This policy sets out the Portsmouth Safeguarding Adults Board (PSAB) approach to fulfilling that statutory duty and sets out the process it will follow in relation to SARs.

PSAB is part of the '4LSAB' (Portsmouth, Southampton, Hampshire and Isle of Wight Safeguarding Adults Boards). This Policy applies only to the PSAB. The 4LSABs are committed to sharing the learning from reviews on a 4LSAB basis.

What is a Safeguarding Adults Review?

A SAB must arrange a SAR when an adult at risk in their area has been seriously harmed or has died and abuse or neglect is suspected and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future. SARs look at how local organisations have worked together to provide services to the adult at risk who is subject to review.

The purpose of a SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. SARs should seek to:

- Determine what might have done differently to prevent the harm or death;
- Identify lessons and apply these to future cases to prevent similar harm again;
- Review effectiveness of multi-agency safeguarding arrangements;
- Inform and improve future practice and partnership working;
- Improve practice by acting on learning; and
- Highlight any good practice identified.

A SAR is completely separate from any investigation being undertaken by the Police or Coroner. It is not a means of apportioning blame or responsibility for what has happened. 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.

Safeguarding Adults Review criteria

The criteria set out in Section 44 of the Care Act 2014 are as follows:

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

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

If the adult is still alive, examples of the circumstances in which condition (2) may be met include:

- the adult would have been likely to have died but for an intervention.
- the adult has suffered permanent harm (either physical or psychological) as a result of the abuse or neglect.
- the adult has reduced capacity as a result of the abuse or neglect.
- the adult has reduced quality of life as a result of the abuse or neglect. This may be due to either the physical or psychological effects of the abuse or neglect.

If the above criteria are met, the SAR will be 'mandatory'.

Section 44(4) also states that the SAB may arrange for a SAR of any other case involving an adult in its area with needs for care and support. This will be a 'discretionary' SAR.

Principles

SARs should reflect the 6 safeguarding principles:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

SARs should be underpinned by a culture of continuous learning and improvement. The statutory guidance states that 'it is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information'. Professionals should be fully involved in reviews and supported to contribute their views openly.

Referral process

Anyone can make a referral, including a professional, family member, city councillor or MP, the Coroner, or member of the public. However, staff should discuss a potential referral with their manager or their organisation's safeguarding team/lead first.

PSAB is keen to encourage all staff who work with adults at risk to make SAR referrals in all cases when they think the SAR criteria may have been met. SAR referrals help the PSAB to ensure lessons are learnt and that organisations continually review and improve their practice and how they work together. It also helps the PSAB to identify early on any failings that may be systemic or large-scale.

Referrals should be made using the referral form which is available on the PSAB website http://www.portsmouthsab.uk/scrs-2/ (see Appendix B). The form should be completed as fully as possible, indicating how the SAR criteria are met and what are the concerns such that a multi-agency review may be needed. The completed form should be sent to psab@portsmouthcc.gov.uk.

Decision to undertake a SAR

All SAR referrals will be considered by the PSAB SAR subgroup. The terms of reference for the SAR subgroup are available in Appendix A.

On receipt of the referral form, the PSAB support team will notify the SAR subgroup Chair of the referral. The referral will normally be discussed at the next SAR subgroup meeting. The Chair may decide to request further information from the referring agency, or other agencies, prior to the SAR subgroup meeting. The SAR subgroup will consider whether further information is needed to assess whether the case meets the SAR statutory criteria. If further information is required, agencies will be requested to complete the 'scoping' document (Appendix D), which gives a brief chronology of their agency's involvement and any issues identified.

Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with care and support needs. If the SAB requests relevant information from a body or person (for example, in the context of a SAR) then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB.

The SAR subgroup will review the information available to establish whether or not criteria for carrying out a mandatory SAR are met. If criteria for a SAR are not met, the SAR subgroup will consider if a discretionary SAR should be undertaken. Decision making will be based on an assessment of the scoping information provided and whether there is potential for multi-agency learning to improve the safeguarding system and practice locally. The SAR decision tool (Appendix E) will be used to support decision making. The rationale for the decision will be clearly documented in the meeting minutes, including identification of the type of abuse or neglect.

If statutory criteria are met, a SAR must be arranged (a 'mandatory' SAR)

If statutory criteria are not met, a SAR may be arranged (a 'discretionary' SAR)

The type of SAR and the methodology used must be proportionate to the circumstances of the case.

Examples of where the PSAB may wish to undertake a SAR where the statutory criteria are not met include:

- where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
- to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.
- where the death may not have been a direct result of abuse or neglect, but where abuse or neglect (for example self neglect) may have been a contributing factor or a key feature in the adult's life prior to their death.
- where there may have been several deaths referred to the PSAB with a similar theme or circumstances (for example, homelessness or substance misuse).

In the event that the SAR subgroup does not approve a review for a case referred to the subgroup, the SAR subgroup will provide the PSAB Independent Chair with a report outlining the rationale for the decision taken. The Independent Chair will make the final decision as to whether or not a SAR will be commissioned. Having made the decision about how to proceed, the Independent Chair will notify the Chair of the SAR subgroup. The decision and the reasons for the decision of the Independent Chair will be recorded in the minutes.

Where the referrer is dissatisfied with this outcome, they should notify the Independent Chair in writing, who will discuss and review (if necessary) the decision with the referrer and Chair of the SAR subgroup.

Homeless deaths

In response to the Government's Rough Sleeping Strategy, the PSAB SAR subgroup will be notified of any deaths of adults who were street homeless. The SAR subgroup will consider the circumstances of the death at its next meeting and a decision will be made on whether scoping information should be sought. The SAR subgroup will consider whether a SAR may be appropriate or whether another type of review (such as a Drug Related Death review led by Public Health) is indicated. The PSAB is committed to identifying learning from all such deaths.

Fire death review process

The 4LSAB Fire Safety Development Group reviews fire deaths and near miss cases in order to learn from them and reduce the risk of these incidents. Cases that meet the following criteria should be considered for a referral to the Fire Safety Development Group:

- Fatality involving a fire
- Fire resulting in life-threatening, life changing or serious injuries
- Fire resulting in near miss, when an individual has / suspected needs of care of support
- Death, serious injury or near miss (any type not just fire related) involving an individual where high fire risks are identified and may have contributed.

Any fire death or near miss which may in addition meet the criteria for a SAR should also be considered for referral to the SAR subgroup.

Interface with other reviews

It is acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents. This policy is not intended to duplicate or replace these and any opportunities to prevent duplication will be encouraged. In some cases, dependent on the specific issues in the case, internal investigation reports may provide adequate information to address the issues identified by the SAR subgroup or it may be that additional reports are required to address any outstanding areas.

If a case also gives rise to concerns about how agencies have worked together to protect children, a referral to Portsmouth Safeguarding Children Partnership (PSCP) will be made. If appropriate, the case will also be considered by the joint PSAB/PSCP SAR/Learning from Cases subgroup.

The SAR subgroup will also consider if any other statutory review criteria may apply in the case in question (such as a Domestic Homicide Review, Multi-Agency Public

Protection Arrangements, Case Review or Mental Health Homicide Review) and will make a referral as appropriate.

There may also be relevant non-statutory review processes, (such as the Learning Disability Mortality (death) Review (LeDeR) programme or the Portsmouth City Council Drug Related Deaths review process. The SAR subgroup will have regard to all other reviews that may be applicable with the aim of minimising duplication and ensuring that cases are reviewed in the most appropriate way. In circumstances where the SAR may overlap with other review processes, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed to minimise avoidable duplication.

Any SAR will need to take account of a coroner‘s inquiry, and/or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

Methodology

The process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. 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 been seriously abused or neglected.

The SAR methodology chosen should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.

All agencies involved in the case should be fully engaged in the SAR process and have the opportunity to contribute their views.

Should there be concerns about an agency's non-engagement with a SAR, this will be escalated in the first instance to the Chair of the SAR subgroup, and ultimately to the PSAB Independent Chair.

Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

A selection of possible SAR methodologies is available at Appendix F. This is not an exhaustive list. A hybrid approach using different methodologies may be taken if appropriate. Appendices J and K set out templates for agencies to complete Individual Management Reviews and case chronologies should the selected methodology require information to be collected in this way. When undertaking the SAR, the records will either be anonymised through redaction or consent should be sought.

Process

The SAR Quality Markers are a tool to support people involved in commissioning, conducting and quality assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs. The PSAB will have regard to the Quality Markers in all aspects of conducting SARs. Appendix H sets out a proforma for use when considering the Quality Markers.

Terms of reference

The SAR subgroup will agree terms of reference for the SAR and these will be published and openly available. The terms of reference will identify the type of abuse or neglect and will include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management. A template is available in Appendix G.

Timescales

SARs must be completed in a timely manner. Once the decision to commission a review has been made, the review process should be completed within six months. In some circumstances this timescale may be extended. The reason for any delays will be recorded in the SAR report and in the SAR subgroup minutes. The Independent Chair will be informed of any delays.

Panel

A SAR panel will normally be convened to oversee the SAR process. Members of the SAR panel will not have had operational involvement or oversight of the case and will be chosen for their relevant expertise. The panel will support the independent author to ensure that individuals and families are included, that the review is informed through engagement with front line practitioners and managers, that the objectives set out in the terms of reference are met, that the report is of the required quality, and that the review is conducted in a timely manner.

The SAR Quality Markers will be used to quality assure the SAR report. SAR authors will be expected to adhere to the standards set out in the Quality Markers and the SAR Panel will be responsible for this quality assurance process.

It will be the role of the panel to ensure the report is factually accurate and based on the evidence gathered during the process. Involved organisations will be provided with copies of reports for comments on factual accuracy prior to the final draft.

Independent author

The statutory guidance requires that 'reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed'. Depending on the circumstances of the case it may be appropriate to appoint a suitably independent reviewer from a PSAB member agency (for example, where the statutory criteria were not met). In other circumstances an independent author with no connection to any Portsmouth agencies will be required.

It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- collaborative problem solving experience and knowledge of participative approaches
- good analytic skills and ability to manage qualitative data
- safeguarding knowledge
- inclined to promote an open, reflective learning culture.

Where an independent author is to be appointed, expressions of interest will be sought from a range of possible candidates and a selection process will be undertaken by members of the SAR subgroup. Portsmouth City Council will be responsible for engaging the independent author.

Managing disagreements

Any disagreements between agencies or with an independent author should be resolved wherever possible through the SAR methodology chosen. Any disagreements which cannot be resolved by this means will be escalated to the Independent Chair.

To maintain the independence of the SAR author, ultimately any disagreements which cannot be resolved will be noted in the SAR Report.

Disputes about the conduct or performance of an independent author will be managed through their contract with Portsmouth City Council.

Roles and responsibilities

SAR roles and functions		
	Generic SAR function	Role
1	Who is ultimately accountable? Including • decision to commission a SAR, • sign-off of the SAR • decide on publication • providing transparency and accountability via the SAB response and annual report • seeking assurance of effective responses by agencies and/or Board	Independent Chair and Executive
2	Who has delegated responsibility for managing the SAR? Including • initial information gathering, • recommendation to proceed or not, • scoping the review, • identifying and commissioning reviewers, • agreeing and publishing the Terms of Reference • agreeing the methodology / model to be used • providing quality assurance and challenge	SAR subgroup
3	Who provides practical day-to-day support for the review? Including: • providing administrative support, • project management support, • means of access to data, • links with staff, • liaison with the Chair	PSAB Manager
4	Who conducts the review and provides independent leadership? • providing independent challenge • ensuring individuals and families are included • ensuring the review is informed through engagement with front line practitioners and managers • ensuring an accessible report is produced • ensuring reviews are conducted in a timely manner.	Reviewer and Panel Chair

6	Who does follow-up to a review? Including: • deciding/leading on immediate action in response to findings • providing evidence of responses	SAR subgroup
7	Who monitors the longer term sustainability of changes and evaluates what difference, if any, has been made?	Quality Assurance subgroup

Involvement of the adult and their family

Adults and their families must always be offered the opportunity to contribute to the review process and receive feedback on the learning outcomes achieved. Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. Adults and their families should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. They should be kept updated at key stages of the review, notified of the publication, and given the opportunity to review the report and findings prior to publication. The independent author will normally be the main contact for the family, though this will be specific to the individuals involved and may be a trusted staff member, key worker, or independent advocate. The SAR subgroup and SAR panel will consider family involvement at every stage of the SAR process from the referral onwards to ensure that family engagement is person centred and that communication settings and methods are appropriate for those involved. Information for adults and families is available in appendices K, L and M.

Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a safeguarding adult review. Under section 68 of the Care Act 2014, an independent advocate must be arranged (where necessary) to support and represent an adult who is the subject of a safeguarding adult review if it is judged they would experience substantial difficulty in participating in the review process.

Publication

SAR reports should:

- provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- be written in plain English
- contain findings of practical value to organisations and professionals

In the interest of transparency and disseminating learning, the presumption will be that an anonymised version of the full report will be published on the PSAB website.

However, in exceptional circumstances with the agreement of the PSAB Executive, this practice may vary, in which case an Executive Summary will be published. The adult and their family will be given the opportunity to contribute to how they would like the adult to be referred to within the report. At the request of the family, the report may use the adult's full name instead of a pseudonym. Staff names and roles, as well as specific agency names, will always be anonymised in the report.

A shared position statement will be agreed between all involved PSAB agencies prior to publishing the SAR report. Media enquiries will be managed through Portsmouth City Council's press office.

SAR reports will normally be accompanied by a learning briefing aimed at disseminating the learning from the review to professionals.

The PSAB will engage with the national SAR library maintained by SCIE to ensure that reviews carried out locally and nationally are logged.

Findings, learning lessons, and implementing recommendations

The SAR subgroup will oversee the development of multi-agency action plans in response to the recommendations from reviews. Multi-agency action plans will be approved by the Executive. The Quality Assurance subgroup will monitor the action plans and provide assurance that the learning from reviews has been embedded and has had an impact.

Findings from SARs will be included in the PSAB Annual Report, along with what actions have been taken, or are planned, in relation to those findings. If the SAB decides not to implement an action then the reason for that decision will be stated in the Annual Report.

The PSAB will engage with the 4LSAB to ensure that learning from reviews is shared regionally and that coordinated action is taken in response to recommendations where appropriate.

APPENDIX A: SAR SUBGROUP TERMS OF REFERENCE

1. Purpose of the Safeguarding Adults Review Subgroup

1.1 To act as a subgroup of the Portsmouth Safeguarding Adults Board (PSAB) to ensure the responsibilities of the Board are carried out in respect of safeguarding adults reviews.

2. Objectives

2.1 To ensure that a Safeguarding Adults Review Policy is in place in compliance with the Care Act 2014 (section 44) and in conjunction with chapter 14 of the Care and Support statutory guidance.

2.2 To improve inter-agency working and better safeguards for adults at risk to ensure the learning is widely disseminated and the adult at risk or their family members are informed and involved in the way they wish to be in accordance with the statutory responsibilities of the PSAB.

2.3 To ensure there is a clear process for commissioning and carrying out safeguarding adults reviews within Portsmouth.

2.4 To ensure that there is fair consideration given to any cases referred for a safeguarding adults review against criteria set and to ensure that the appropriate methodology is selected, eg. traditional safeguarding adults review approach, systems learning methodology or smaller scale partnership review (which may be appropriate for cases where safeguarding adults review criteria may not be met but lessons can be learned).

2.5 To establish whether there are lessons to be learned from cases under review, about the way in which local professionals and agencies work together to safeguard adults at risk.

2.6 To engage with the national SAR library maintained by SCIE to ensure that reviews carried out locally and nationally are logged.

2.7 To engage with the 4LSAB to ensure that learning from reviews is shared regionally and that coordinated action is taken in response to recommendations where appropriate.

2.8 To make recommendations to the PSAB about how learning from reviews can be effectively shared with practitioners to inform and improve local practice.

2.9 To oversee the development of multi-agency action plans in response to the recommendations from reviews.

3. Meeting Arrangements

3.1 The Chair of the Safeguarding Adults Review Subgroup will be nominated by the Portsmouth Safeguarding Adults Board for a term of two years. A Vice Chair will be nominated for the same period of time.

3.2 The Safeguarding Adults Review Subgroup will plan to meet monthly. If a meeting is not needed it will be cancelled.

3.3 If members are unable to attend it is an expectation of the subgroup that they will send a suitable alternative representative as outlined in 4.2.

4. Membership

4.1 The SAR Subgroup will be comprised as follows:

Head of Safeguarding	NHS Portsmouth CCG
Adult Social Care Safeguarding lead	Portsmouth City Council
Serious Case Reviewer	Hampshire Constabulary
Acute Hospital Representation	Portsmouth Hospitals University NHS Trust
Community Health Provider Representative	Solent NHS Trust
Safeguarding Manager	South Central Ambulance Service NHS Trust
Strategic Lead for Domestic Violence and Abuse	Portsmouth City Council
Principal Social Worker	Portsmouth City Council
Housing representative	Portsmouth City Council
Board Manager	Portsmouth Safeguarding Adults Board

4.2 Members should have sufficient seniority within their own agency to speak on its behalf, to commit resources, agree actions and to represent their agency should the SAR subgroup need to hold it to account.

4.3 Hampshire Care Association will be invited to attend as required to represent independent providers.

4.4 Public Health will be invited to attend as required.

4.5 Professional leads from other statutory or non-statutory agencies may be requested to attend where an individual SAR is relevant to that service.

4.6 The meeting will be quorate when there is representation from Health, Police and Local Authority.

5. Safeguarding Adults Review Subgroup Business Process

5.1 Safeguarding Adults reviews will be undertaken in accordance with the agreed PSAB SAR Policy. This guidance will be reviewed and updated to reflect current legislative and policy requirements as necessary and in consultation with partner agencies.

5.2 Any organisation or professional who becomes aware of a case which may meet the criteria for a safeguarding adults review should refer it (directly or via their organisation's PSAB representative, according to their organisation's policy) to the Portsmouth Safeguarding Adults Board. See http://www.portsmouthsab.uk/scrs-2/ for further details.

5.3 Where it is considered by the Chair or the Subgroup that the case may meet the criteria for a safeguarding adults review, the Portsmouth Safeguarding Adults Board Manager will inform each of the agencies known to have had involvement with the person at risk at the time of the incident and request scoping information about that involvement in advance of the next practicable Subgroup meeting.

5.4 The Safeguarding Adults Review Subgroup will review the information available to establish whether or not criteria for carrying out a mandatory safeguarding adults review are met. If criteria for a safeguarding adults review are not met, the Safeguarding Adults Review Subgroup will consider if a discretionary safeguarding adults review undertaken. Decision making will be based on an assessment of the scoping information provided and whether there is potential for multi-agency learning to improve the safeguarding system and practice locally. The rationale for the decision will be clearly documented in the meeting minutes, including identification of the type of abuse or neglect.

5.5 In the event that the Safeguarding Adults Review Subgroup approves a review, the Safeguarding Adults Review Subgroup will provide the PSAB Independent Chair with a report outlining the rationale for the decision taken. The Independent Chair will make the final decision as to whether or not a Safeguarding Adults Review will be commissioned. Having made the decision about how to proceed, the Independent Chair will notify the Chair of the Safeguarding Adults Review Subgroup. The decision and the reasons for the decision of the Independent Chair will be recorded in the minutes.

5.6 If PSAB Independent Chair decides that a safeguarding adults review should be undertaken, the Safeguarding Adults Review Subgroup will be responsible for drawing up clear terms of reference for that specific review and for establishing a review panel to oversee the process. As a

minimum, the review panel will include representation from the statutory members of PSAB ie. Adult Social Care, Police and NHS.

5.7 If a case also gives rise to concerns about how agencies have worked together to protect children, a referral to Portsmouth Safeguarding Children Partnership will be made. If appropriate, the case will also be considered by the joint PSAB/PSCP Safeguarding Adults Review/Learning from Cases subgroup. The Safeguarding Adults Review Subgroup will also consider if any other statutory review criteria may apply in the case in question (such as a Domestic Homicide Review, Multi-Agency Public Protection Arrangements, Case Review or Mental Health Homicide Review) and will make a referral as appropriate.

5.8 Where other statutory review processes, coronial proceedings, or a criminal or other statutory body investigation run in parallel with the safeguarding adults review, the Safeguarding Adults Review Subgroup will be responsible for ensuring the interfaces between respective processes are managed appropriately and effectively. Declarations of interest and any conflicts of interest will be identified at all meetings and during reviews.

5.9 The Safeguarding Adults Review Subgroup will consider key themes arising from Safeguarding Adults Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews carried out in other local authority areas and will make recommendations to the PSAB about the dissemination of key learning using appropriate communication methods, including the national SAR library maintained by SCIE.

6. Governance and Reporting Arrangements

6.1 PSAB members will be responsible for sharing the safeguarding adults review report within their own agencies. They will also be responsible for ensuring that appropriate actions to share and facilitate learning have been put in place within their organisation and that these are monitored.

6.2 The Chair of the Safeguarding Adults Review Subgroup will update the PSAB on the progress of the group and any safeguarding adults review at each Executive Group meeting and Board meeting.

6.3 The PSAB Executive Group will ultimately be responsible for agreeing a safeguarding adults review report and the arrangements for its publication.

6.4 The SAR subgroup will be responsible for ensuring that a multi agency action plan is produced to address the findings of the review. This task may be delegated to the review panel or other individuals. This action plan will be signed off by the Executive Group. The action plan will be monitored by the PSAB Quality Assurance Subgroup.

6.5 The terms of reference of this group will be reviewed on annual basis.

APPENDIX B: SAR REFERRAL FORM

Referral Form for

Safeguarding Adult Review or Child Safeguarding Practice Review

****Please note: this form is not to be used to refer for services (including referrals to MASH). It is only to be used to refer to the Portsmouth Safeguarding Adults Board/Portsmouth Safeguarding Children Partnership for multi-agency review****

When completed please send this referral form as a password protected document to one of the following addresses**:**

If you are completing this form to request consideration of a case involving an **adult**, please email it to: psab@portsmouthcc.gov.uk

If you are completing this form to request consideration of a case involving a **child**, please send via secure email to: PSCP@portsmouthcc.gov.uk

The criteria to commission a Safeguarding Adult Review or a Child Safeguarding Practice Review are as follows:

Child Safeguarding Practice Review (Chapter 4 Working Together March 2018)

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review:

1. **Abuse or neglect of child is known or suspected and**
2. The child has **died or been seriously harmed**

Meeting the criteria does not mean that we must automatically carry out a Local Child Safeguarding Practice Review. We must determine whether a review is appropriate, taking into account **that the overall purpose of a review is to identify improvements to practice.**

Does the case highlight the following with regard to safeguarding children and promoting their welfare:

- Improvements that need to be made?
- Recurrent themes?
- Concerns regarding how one or more agencies worked together?

Safeguarding Adult Review (Section 44 Care Act 2014)

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **AND**

(b) Condition 1 or 2 is met.

(2) Condition 1 is met if:

(a) The adult has died, **AND**

(b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:

(a) The adult is still alive, **AND**

(b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

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

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

1. Referral Details	
Referrer's Name & Role	
Agency	
Tel. No.	
Email	
Date of Referral	
State if referral is for a SAR or CSPR	
Details of any other review, or investigation e.g. SIRI, criminal investigation, DHR etc.	

2. Details of Subject	
Full name	
Any other known names	
Date of Birth	
Date of death or incident leading to serious abuse/harm being caused	
Ethnicity	
Gender	
Current address	

Previous address	
School / Nursery / Residential Home / Care Home etc. (if applicable)	

3. Details of Significant Persons e.g. parent, carer, sibling, son, daughter etc.

(complete additional row for each additional significant person)

Full Name	Date of Birth	Address	Relationship to Subject

4. Agencies known to be involved with the Subject

Please list the names of all services you know to be involved with the subject, including the name of the relevant professional and their job role where possible:

-
-
-
-
-
-

5. Reasons for Referral

(a) Reasons for Referral for Safeguarding Adult Review (please tick)	
Adult with needs for care and support	
Concern about multi agency working	
Adult has died AND death linked to abuse or neglect	
Adult is alive having experienced serious abuse or neglect	
Other reason (specify)	
(b) Reasons for Referral for Child Safeguarding Practice Review (please tick)	
Abuse or neglect of a child is known or suspected.	

A child has died (including suicide)	
A child has been seriously harmed	
Concern about multi agency working	
Other reason (specify)	

6. Case Outline
Please give a summary of the circumstances of this case and explain why you feel this case should be considered for a safeguarding adult review, child safeguarding practice review, single agency review, or multi-agency/partnership review.

APPENDIX C: ONE MINUTE GUIDE TO MAKING A SAR REFERRAL

What is a Safeguarding Adults Review (SAR)?

Safeguarding Adults Boards are required by the Care Act 2014 to carry out a Safeguarding Adult Review when an adult at risk in their area has been seriously harmed or has died, and abuse or neglect is suspected, and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future. Safeguarding Adult Reviews look at how local organisations have worked together to provide services to the adult(s) at risk. A Safeguarding Adult Review is completely separate from any investigation being undertaken by the Police or Coroner. It is not a means of apportioning blame or responsibility for what has happened.

The Portsmouth Safeguarding Adults Board (PSAB) is keen to encourage all staff who work with adults at risk to make SAR referrals in all cases when they think the above criteria may have been met. SAR referrals help the PSAB to ensure lessons are learnt and that organisations continually review and improve their practice and how they work together. It also helps us to identify early on any failings that may be systemic or large-scale.

How do I make a referral?

You can download the referral form from the PSAB website. Please complete it as fully as possible and send the completed form to psab@portsmouthcc.gov.uk.

Who can make a referral?

Anyone can make a referral, including a member of the public. However, please discuss your referral with your manager or your organisation's safeguarding team/lead first.

What happens next?

All referrals are reviewed carefully by the SAR sub-group of the PSAB. More information will be requested from agencies involved in the case (such as a detailed chronology of their contact with the person who has been harmed). The sub-group will then make a decision on whether the criteria for commissioning a SAR have been met. If they have, the Board will proceed to undertake a SAR. If the criteria have not been met, the Board may decide to undertake a discretionary review. The Board Manager will contact you to let you know the outcome of your referral.

How is a SAR referral different from a safeguarding referral?

The SAR process is about learning lessons about harm which has already occurred so that it can be prevented in future. The PSAB does not safeguard individuals or investigate current concerns. If you have current concerns about an adult at risk, you need to make a referral to the Adult Multi-Agency Safeguarding Hub (MASH) by emailing PortsmouthAdultMASH@portsmouthcc.gov.uk or phoning 023 9268 0810.

The referral form for a current concern is available on our website http://www.portsmouthsab.uk/reporting-concerns/.

Where can I get more information?

More information about SARs (including the referral form) is available on the PSAB website http://www.portsmouthsab.uk/scrs-2/.

APPENDIX D: SAR SCOPING DOCUMENT

Portsmouth Safeguarding Adults Board
Safeguarding Adults Review Scoping Document

This information will be collated and used by the PSAB to inform the decision about whether or not a Safeguarding Adults Review should be undertaken. Please briefly answer the questions below and return securely by **DATE**

This document contains sensitive personal data so please ensure your email is secure or encrypted.

Name of agency completing the form:	
Name of individual completing the form:	
Role of individual completing the form:	
Contact details:	

For completion by Safeguarding Adults Review Subgroup – from referral information:	
Referrer's name and agency:	
Details of adult(s) with care and support needs:	
Name:	
Date of Birth:	
Date of Death (if applicable):	
Address:	
Care and support needs:	
Outline of the incident:	
Factors that suggest a SAR is required:	
Other relevant information provided:	
Agencies known to be involved:	

For completion by Safeguarding Adults Review Subgroup – from referral information:
Agencies to complete scoping document:

For completion by the responding agency:

Question	**Response**
1. Has your agency had any involvement with the adult(s)?	
2. Period of involvement for your agency :	
3. Provide a summary of your agency's involvement and include any relevant information that will assist the decision making process. Where relevant, include specific dates of any significant events or contacts.	
4. Has your agency undertaken any formal investigation and/or identified any learning?	
5. Are there any issues that you have identified that you consider require further investigation from other agencies or your own?	

Question	Response
6. Is your agency aware of involvement by any agency not listed above? (Please list)	
7. Is your agency of the view that any form of multi-agency review should be undertaken? Please explain your response e.g. What areas do you feel should be considered within a review?	

APPENDIX E: SAR DECISION TOOL

Name and Role of person completing form:	Organisation:	Date:

Details of adult the case relates to:

Purpose of a Safeguarding Adults Review

The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, and about the way in which local professionals and agencies worked together to safeguard the adult at risk.

The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for future practice where this is necessary.

The purpose of the SAR is to:

- Determine what might have done differently to prevent the harm or death;
- Identify lessons and apply these to future cases to prevent similar harm again;
- Review effectiveness of multi-agency safeguarding arrangements;
- Inform and improve future practice and partnership working;
- Improve practice by acting on learning; and
- Highlight any good practice identified.

Criteria for conducting a safeguarding adult review

The SAB must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if **a) AND b) OR c) are met**:			
	Met	Not met	Comments
a) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult			
b) The person died and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)			
c) The person is still alive but the Safeguarding Adults Board knows or suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.			

SAR decision making

If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. Serious Incident Requiring Investigation, Critical Incident Review, etc.), this should take place without delay and in line with the organisation's internal policy requirements.

A referral for a SAR should be a considered decision, informed by consideration and evaluation of all relevant information.

The following decision making criteria will be used to assess all SAR referrals:

	Yes	No	Comments
THE CASE:			
1. Do the concerns relate to a person with needs of care and support – whether or not in receipt of services at the time of death or injury?			
2. Has the cause of death been established?			
3. Has any safeguarding enquiry process concluded?			
4. Is there evidence of a causal link between the death and abuse, neglect or acts of omission?			
5. What type of abuse or neglect has the person suffered (may include self neglect)			
6. Is the harm caused or death judged to have been preventable?			
7. Do concerns exist about the way partners worked together to safeguard the adult? Consider the Making Safeguarding Personal principles and the impact of protected characteristics on case management.			
8. Do the concerns relate to systemic failings relating to multiple organisations? Have all parts of the system been considered - provider and commissioner, direct practice and oversight?			

9. Is there potential to identify learning to improve the local safeguarding system, multi-agency practice and partnership working? Consider also learning from good practice.			
10. Will the SAR add value to any investigations or reviews already carried out and not duplicate? Have alternative statutory review pathways or a single agency review been considered?			
LOCAL CONTEXT:			
11. Have there been any recent SARs or SAR referrals with similar themes or circumstances? If so, what are the implications for the size or scope of this potential review?			
12. Are any of the issues raised in this case relevant to the SAB's strategic plan?			
13. Do other quality assurance and feedback sources (e.g. audits/complaints) suggest the kind of practice issues in the case and/or their systemic causes are new, complex or repetitive?			

Discretionary reviews

The statutory guidance to the Care Act (2014) clarifies that SABs are free to arrange SARs in other situations involving an adult in its area with needs for care and support where the statutory criteria are not met

Methodology

- The SAB needs to weigh up what review methodology will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
- The size/scope of the SAR should be appropriate to the case and local context.

Decision (including relevant comments):

APPENDIX F: SAR METHODOLOGIES *(with thanks to Richmond and Wandsworth Safeguarding Adults Board)*

APPENDIX G: SAR TERMS OF REFERENCE

Safeguarding Adults Review: INSERT NAME

Terms of Reference

1. Introduction

The primary purpose of a Safeguarding Adults Review is to draw out organisational learning about how the local agencies are working together, to support improvement.

This review concerns NAME:

- *Include brief details of the adult and the circumstances which led to the SAR*
- *This section must identify the type of abuse or neglect*

2. Legal framework

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (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 Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

The PSAB SAR subgroup considered the case referral for NAME on DATE and concluded that the above criteria had been met. The recommendation to commission a SAR was approved by the PSAB Independent Chair on DATE.

3. Aims and objectives

a.
b.

4. Scope

The SAR will cover the following timeframe: DATE to DATE. Contextual information will also be included outside this time period.

The SAR will address the following key questions:

1. This section must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.
2.

5. Agencies involved

-

6. Context

- This section should include links to other reviews (PSAB and other local/national reviews), research evidence, findings from quality assurance/feedback sources eg audits/complaints, relevance to PSAB strategic priorities

7. Methodology

The methodology for the review will be….

8. Independent author

The Independent Author for the SAR is….

9. Membership of SAR panel

A multi-agency SAR Panel will be appointed to oversee the delivery of the SAR.

Member	Role/Agency

10. Administration

The Panel will be supported by the PSAB Manager and Administrator. The Board Manager will coordinate all correspondence and information moving between the Panel Chair, individual agencies, Independent Author, Panel members and the SAR subgroup. All personally identifiable information will be exchanged using secure methods.

11. Accountability

The SAR subgroup is responsible for defining clear terms of reference for the SAR and for establishing the SAR panel. The PSAB has ultimate responsibility for signing off the SAR and agreeing any recommendations.

12. Involvement of family members

13. Timescales

The review will aim to complete its report within 6 months and publish a summary of the learning and recommendations within 8 months. Key dates will be as follows:

Milestone	**Date**
Scoping and Terms of Reference approved	
Independent Author and Panel appointed	
Chronologies completed	
First panel meeting	
Meetings with staff/family	
First draft of report	
Final draft of report	
Final draft of report presented to SAR subgroup	
Report presented to PSAB	
Family shown final report	
Publication	

14. Publication

The report will be written for publication. In the interest of transparency and disseminating learning PSAB will publish the SAR report unless this is not possible for reasons of confidentiality. References to individuals will be anonymised within the SAR report. An Executive Summary along with a learning briefing for practitioners will also be published on the PSAB website. The findings from the SAR will also be

published in the Annual Report. The final report will be shared with the family prior to publication.

15. Legal advice

Legal advice will be supplied by Portsmouth City Council in the first instance unless a conflict of interest should arise, in which case independent legal advice will be sought.

16. Media

A shared position statement will be agreed between all PSAB agencies prior to publishing the SAR report. Media enquiries will be managed through Portsmouth City Council's press office.

17. Confidentiality

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared outside agencies represented on the panel without prior consent from the SAR Panel Chair or the SAR Subgroup Chair.

These Terms of Reference have been drawn up by the PSAB SAR subgroup in consultation with key agencies and the PSAB Independent Chair.

APPENDIX H: SAR QUALITY MARKERS

The Quality Marker	The Quality Statement	Questions to ask when considering compliance	Comments/Outcomes
1. Referral	The case is referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner	Those with delegated responsibility for managing SARs 1. Does the referral state explicitly: • what kind of abuse or neglect the person is known or suspected to have suffered • whether the person has died, or experienced serious abuse and/or neglect and survived • and whether this happened in the SAB's area • what concerns there are about how agencies worked together. 2. Alternatively, does the referral give a clear rationale for a discretionary review, whether: • to learn from good practice in the case • to review practice issues featured in the case before abuse or neglect has occurred, in order to pre-emptively tackle them • or for any other reason?	

		3. Does the referral document what is known about protected characteristics as codified by the Equality Act 2010, including race, culture and ethnicity? 4. Does the information provided evidence the rationale given for why the case is being referred for consideration for a SAR, and include relevant supporting information? 5. Are explanations provided for any delays in the referral? Those providing practical support 1. Have details of ethnicity and other protected characteristics relevant to the SAR referral been appropriately recorded? 2. Where the person is alive, is enough known about their experience to explore the impact of the abuse and/or neglect in a person-centred way, which may include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness? 3. Is the identity of the referring agency or other source clear and recorded?	
2. Decision making- what kind of SAR, if any	Factors related to the case and the local context inform decision making	Those ultimately accountable 1. Is the rationale for the decision clear and defensible, paying close attention to the Care Act 2014 and	

	about whether a SAR is required and/or desired and initial thinking about its size and scope. The rationale for these decisions is clear, defensible and reached in a timely fashion.	Making Safeguarding Personal principles? 2. Has a clear legal mandate been established reflecting either a mandatory SAR [sections 44(1), (2) and (3) Care Act 2014] or discretionary SAR [section 44(4)]? 3. Is there transparency about any conflicts of interest and how they have been managed? 4. Is it evident how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 have been considered? 5. Has independent challenge to decision making been considered? 6. Have SAB member agencies had the opportunity to contribute to decision making process (whether or not the SAB has delegated decision making authority to the Independent Chair) through participating in a SAB subgroup or by other means? 7. Is there transparency for SAB members on the decision-making process and outcomes? 8. Has legal advice been sought, if appropriate, to check the lawfulness of the decision making? 9. Are explanations provided for any delays in decision making?	

		10. Is the clarity of purpose (QM 4) evident in decision making rationale? Those with delegated responsibility 1. Has meaningful multi-agency discussion informed the recommendation to the Chair? *The case* 2. Has there been appropriate challenge about how an adult with care and support needs is defined? 3. Have the kinds of abuse and/or neglect the person suffered been specified? 4. Have discussions about the abuse and neglect suffered by the person included self-neglect? 5. Where the person has survived, has there been adequate consideration of their experiences to support a person-centred assessment of whether the abuse and/or neglect experienced was serious? 6. Have discussions about any cause for concern about the quality of safeguarding practice, overtly referenced the principles of Making Safeguarding Personal? 7. Have discussions about any cause for concern about the quality of safeguarding practice overtly	

		considered how race, culture, ethnicity and other protected characteristics, as codified by the Equality Act 2010, may have impacted on case management, including recognition of unconscious bias? 8. Have discussions about any cause for concern about working together to safeguard, included consideration of all parts of the system - provider and commissioner, direct practice and oversight? 9. Has the right balance been struck between timely decision making and the amount of time it is going to take to determine whether a SAR is mandatory in this particular instance? 10. Have the benefits of using the discretionary power of Section 44 (4) of the Care Act 2014 in order to proactively learn from practice in the case, been considered in tandem with identifying whether the circumstances meet the criteria for a mandatory SAR? 11. Is there evidence of sufficient good practice in the case that may allow learning about supportive system conditions which can be shared across the partnership?	

		12. Have alternative statutory review pathways or a single agency review been considered? *Local context* 13. Do other quality assurance and feedback sources (e.g. audits/complaints) suggest the kind of practice issues in the case and/or their systemic causes are new, complex or repetitive? 14. Are any of the issues and the system conditions indicated in this case, relevant to the SAB strategic plan and/or current and future priorities? 15. Has it been confirmed whether similar cases and/or circumstances have been subject of an earlier SAR locally, or the target of recent improvement activity, with implications for decision making about the size and scope of the potential review? • For example, are there any different features in this case that may generate new insights? • For example, does the focus need to be moved to understanding the extent to which change has been	

		achieved since the previous SAR and why? 16. Has it been confirmed whether any similar cases or circumstances have been considered recently for a SAR, that suggest a local learning need in this practice area? 17. Has the recommendation to the SAB or Chair about whether a SAR is needed given an indication of the appropriate size/scope given the case and context? Those providing practical support 1. Have all key agencies provided information about their involvement? 2. Have neighbouring SABs been asked for information, if the person lived outside the SAB area? 3. Has intelligence from other quality assurance and feedback sources, that is relevant to practice in this case, been gathered E.g. audits/benchmarking, complaints and previous SARs? 4. Are you clear whether the s42 is completed (where relevant)? 5. Have other parallel processes been identified? 6. Is the decision-making rationale clearly documented on all records?	

3. Informing the person, their family or other important network	The person, relevant family members, friends and network are told what the Safeguarding Adult Review is for, how it will work and the parameters, and are treated with respect.	Those with ultimate accountability 1. Have you overtly championed the importance of prompt clear, accessible, compassionate and respectful correspondence with the person and relevant family or network, on accepting the recommendation to proceed or not with a SAR? Have you noticed and praised its completion? 2. Has there been overt encouragement and support from all partners for honest communication to address legitimate questions posed by the person, relevant family members, or other important network? 3. Have you addressed any apparent reticence from partners to progress initial engagement with person and/or family members? Those with delegated responsibility 1. Has the person subject of the SAR, relevant family members, friends and members of their social network been informed at the earliest stage possible? 2. Have the purpose, process and parameters of the SAR been communicated in the most appropriate setting or method to ensure that these can both be	

		understood and convey respect to those involved? 3. Are opportunities being offered to discuss any queries or clarifications about the SAR purpose, and do they give the individuals a realistic chance of doing so? 4. Has advice and support been sought from partners who might be more experienced in involving family members in incident reviews, such as NHS roles related to Mental Health Homicide Reviews and/or Domestic Homicide Reviews? Those providing practical support 1. Has information been gathered from agencies previously in touch with the person and/or family member, about their preferences in terms of communication with professionals and any support requirements? 2. Is the standard SAB correspondence available for use with family members in this SAR about the purpose, process and parameters of the SAR and is it adequately clear, accessible and kind? 3. Has discussion between the reviewer(s) and those with delegated responsibility created clarity and agreement about the parameters of	

		the review (QM5) to be communicated to the family?	
4. Clarity of purpose	The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory process, with the purpose of organizational learning and improvement, and acknowledges any factors that complicate this goal	Those with ultimate accountability 1. Have you demonstrated strong overt leadership about the practical value of the SAR in surfacing learning about the causes of strengths and difficulties in safeguarding practice and furthering improvement activity? 2. Have you demonstrated clear expectations that people use the escalation pathway to you, if there is any non-engagement by providers, commissioners or other agencies involved in the SAR? 3. Have any complicating factors been honestly acknowledged? 4. Has consultation with legal departments been sought if appropriate? Those with delegated responsibility 1. Have you communicated with all the relevant parties (SAB members, involved agencies/provider/commissioner, leaders, legal advisors, as well as practitioners) a positive message about the statutory nature of the SAR, and restated its practical purpose of surfacing learning about the causes of strengths and	

		difficulties in safeguarding practice and furthering improvement activity? 2. Have you clarified the kind of 'learning' that this SAR is intended to generate, or how it is going to progress improvement activity in order to minimise misunderstandings? 3. Is what you are saying underpinned by an agreed organisational accident or incident causation model (such as James Reason's 'swiss cheese' model and variations thereof) to aid clarity and provide suitable vocabulary? 4. Has there been a multi-agency discussion regarding any possible tensions and complications, so that they can be to be recognised and managed as best as possible? Those conducting the review 1. Are you confident that all parties are on the same page regarding the purpose of the SAR? 2. Have you initiated overt discussion about any areas of potential disagreement?	
5. Commissioning	Decisions about the precise form and focus of the SAR to be commissioned	Those with ultimate accountability 1. Is the precise form and focus that has been agreed for this SAR best suited to have practical value by	

	take into account a range of case and contextual factors in order to make the SAR proportionate to the potential for learning and improvement. Decisions are made with input from the SAB Chair and members and in conjunction with the reviewers.	illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities (see QM4) to the benefit of adults and their families? 2. Have you explicitly endorsed those with delegated responsibility to identify an approach to the SAR that is fit for purpose for this case and current context, and moves away from a one-size-fits all approach that assumes a set process and long report? 3. Is there adequate clarity in the commissioning specification about the proposed approach agreed, to allow confidence in the methodology being used and similar confidence in the analysis and conclusions? 4. Are there any issues regarding the capacity of practitioners, SAB and member agencies, and experienced / qualified reviewers that may impact on the feasibility and/or quality of this SAR? Those with delegated responsibility 1. Have multi-agency partners with delegated responsibility been involved in discussions with the reviewers about the precise form, focus and approach, as opposed to	

		delegating these decisions to the Business Manager or equivalent? 2. Have you agreed how learning from the SARs of other SABs, as well as research evidence, will be synthesized, in order that it can be used to develop a proportionate approach to the SAR that builds on the evidence base about what good looks like, barriers and enablers, rather than starting afresh? 3. Has detail from any parallel processes or statutory reviews been utilized to avoid unnecessary duplication and agree joint-commissioning where appropriate (while not losing focus of SAR Care Act requirements of the process)? 4. Have discussions about the precise form and focus of the SAR built on initial information gathering about case and local context (QM 2), drawing on the right range of information including: • Evidence of impact on adults with care and support needs and their families, including of any serious public concern and/or potential media interest	

		• Other quality assurance and feedback sources e.g. audits/complaints • Relevance to SAB strategic, current and/or future priorities • Previous SARs locally, regionally and nationally (as relevant). **Agreeing the right approach** 5. Where it has been agreed that the review will focus on surfacing learning about what is facilitating or obstructing good practice in the case, have you made it clear whether or not you expect the SAR to: • establish whether what obstructed or facilitated good practice in the case, was more widespread at the time and/or • assess the current relevance of past practice barriers/facilitators identified in the case being reviewed? 6. Where a similar case has been subject of an earlier SAR and/or the target of recent improvement activity, has there been adequate consideration of what a	

		proportionate approach would look like? • For example, beginning with the previous learning identified about barriers and enablers to good practice, and improvement actions proposed, and commissioning the new SAR to focus on where good practice has been facilitated, where barriers to good practice still need to be confronted and what has obstructed change, or whether the barriers have changed since the original SAR. • For example, targeting the SAR only on practice areas / issues that appear to be new in comparison with the case previously reviewed. 7. If consideration of the case and wider intelligence has identified an urgency to identifying and tackling the barriers to good practice in particular areas, have approaches that allow a speedy turn-around of learning been considered? • For example, the SAR In Rapid Time model.	

		8. Where similar cases or circumstances have been considered recently for a SAR, that suggest a local learning need in this practice area, has consideration been given to a themed SAR? **Methodological rigour** 9. Has there been adequate expertise in research methods and/or quality improvement to inform agreement of the detail of the methodology proposed? 10. Does the approach proposed strike the right balance between methodological rigour and proportionate use of resources/capacity relative to the learning and impact expected? Those conducting the review 1. Have you been allowed adequate influence on the scope, nature and approach for the review? 2. Has the scoping process covered all areas and issues covered by the SAR Quality Markers? 3. Have agreements been captured with suitable clarity and specificity? 4. Are there any disagreements or conflicts of interest that need to be escalated at the start?	

		Those providing practical support 1. Have you made available a standard scoping document anchored in the SAR Quality Markers to support decision making about the form, focus and approach for this SAR? 2. Have decisions about the precise form and focus of the SAR to be commissioned been captured in a Terms of Reference that is published at the start of the SAR? 3. Has the Terms of Reference consideration, as standard, of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management, including recognition of unconscious bias. 4. Is there agreement about what level and precision of detail is required to be captured about the case characteristics and where this will be logged, e.g. in the report or in a database managed by the SAB?	
6. Governance	The Safeguarding Adult Review achieves the requirement for independence AND ownership of the	Those with ultimate accountability 1. Are you assured that you have adequate line of sight on the progress of the SAR including: i. Has decision-making distinguished between	

	findings by the Safeguarding Adults Board and member agencies	mandatory and discretionary SARs, recognising that all SARs are statutory? ii. Has decision-making on referrals been timely? iii. What types of abuse and/or neglect are the main and secondary concerns? iv. What methodology has been chosen and why? v. What methods for gathering/exploring information have been chosen and why? vi. What positive/negative reasons for delay have impacted on the process? vii. Have services and agencies cooperated as required? viii. What approach has been taken to subject and family involvement? ix. Do annual reports provide required information: SARs, findings and actions taken in response? x. How has SAR quality been assured? xi. How has the SAB captured the outcomes of action taken?	

		xii. Have reasons for decisions at all stages of the process been recorded?[1] 2. Are you confident that everyone has clarity about when and how issues should be escalated? 3. In a review involving other SABs, have you achieved clarity and agreement from the outset about who leads the SAR (e.g. area for whom most learning is likely to emerge) and governance arrangements? 4. Have you demonstrated strong, overt leadership about the significant degree of objectivity combined with sufficient understanding of context and organisational arrangements, that is required for rigorous SAR analysis and conclusions? 5. Have you demonstrated clear expectations that if a consensus view cannot be reached in any aspect of this SAR related to the analysis and findings, the differing positions will be articulated in the final report? Those with delegated responsibility 1. Are there clear governance arrangements for this particular SAR in place from the outset of the process?	

		2. Has the system for quality assurance of the process and sign-off of the report been set out clearly from the start? 3. Do the agreed quality assurance mechanisms manage the tension in a fair and balanced way, between the independence of reviewer(s) and local involvement, and avoided agency defensiveness and inappropriate pressure? 4. Are senior managers being kept up to date in order to cultivate ownership of the conclusions, and avoid any surprises about the learning being identified? 5. Are there mechanisms in place to allow challenge to the information and analysis of the review, so that the findings/ recommendations have been thoroughly considered before the report is finalized and taken to the SAB? Those conducting the review 1. Are you clear from the start about who is responsible for what, how and when to expect quality assurance and oversight, and what the routes for escalation will be? 2. Have people of the right level of seniority been identified to be	

		involved, given the specifics of this particular SAR? Those providing practical support 1. Have all decisions been recorded with appropriate detail and including the rationale? 2. Have reasons for any delay or departure from statutory guidance all been recorded? 3. Are mechanisms in place to inform the SAB Chair of any delays or other delivery issues in this SAR and reasons for them?	
7. Management of the process	The Safeguarding Adult Review (SAR) is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources.	Those with ultimate accountability 1. Have you made yourself available to provide leadership in addressing any challenges that arise during the SAR? 2. Has there been clear messaging from senior leads of statutory partners that how the SAR is conducted is important, with an expectation that people are cared for and relationships fostered through the process? Those with delegated responsibility 1. If there have been any changes in relation to key personnel, administrative support or reviewer capacity, has there been a reflection	

		on how that may impact on the SAR and any action needed? 2. Does the provision of administrative support and reviewer capacity match expectations about the quality and timing of the SAR outputs? 3. Is there enough slack in the plan to allow for legitimate delays? 4. Is there sufficient feedback on the process to have oversight of the experience of those taking part? Those conducting the review 1. Has best use been made of project management tools and approaches to support timely delivery of this SAR? 2. Have any known sensitivities, tensions or conflicts been shared with you in order that you can endeavour to address them appropriately? Those providing practical support 1. Is there a clear plan with allocated roles and responsibilities for the transmission of information? 2. Are mechanisms in place to inform the SAB Chair of any delays and reasons for them?	
8. Parallel processes	Where there are parallel processes the SAR is managed	Those with ultimate accountability 1. Have you supported, where necessary, efforts to communicate	

	to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.	and cooperate with all relevant processes, to achieve the best fit for the circumstances? Those with delegated responsibility 1. Has early contact been made with all those managing all relevant processes, to achieve the best fit between them for the circumstances, considering all key stages of respective processes? 2. Where necessary has there been early discussion with the police; Crown Prosecution Service (CPS); leads of any Domestic Homicide Review, Local Child Safeguarding Practice Review; Mental Health Homicide Review; and Coroner to consider any information relevant to criminal or other proceedings and the SAR. Have you considered whether a face-to-face meeting may be necessary? 3. Is it clear who owns documents generated through this SAR so that the relevant body can make judgements on their disclosure? 4. Have relationships that the SAB has established with the Crown Prosecution Service (CPS) and Coroner been used to support plans to protect the person's anonymity? Those providing practical support	

		1. Are note of interviews and meetings, and copies of reports that might be considered relevant to criminal proceedings, being retained? 2. Is an index being maintained of material generated by the SAR so it can be readily considered to see if it is disclosable?	
9. Assembling information	The Safeguarding Adult Review (SAR) gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors.	Those with ultimate accountability 1. Has the Board positively and clearly articulated the statutory duty on all agencies both to cooperate and contribute to this SAR and to provide information when the SAB exercises its power to request it (section 45 of Care Act 2014)? 2. Has there been consideration of whether non-compliance with section 45 of the Care Act 2014 is likely from particular agencies, and how best to address this as early as possible? 3. Have you demonstrated clear expectations that people use the escalation pathway to you, in respect of non- or partial engagement by participating agencies or individuals? Those with delegated responsibility 1. Does the specification of information required and the level of detail	

		needed, match with decision making about the precise form and focus, and approach agreed for the SAR commissioned (QM5)? 2. Has decision making about what data to seek from which sources been mindful of the need to be proportionate relative to the practical value of the SAR (QM4)? 3. Are all the ways proposed for gathering relevant information efficient, matching the proportionality agreed for the SAR, and minimizing demand on all participants? 4. Is everyone clear that any requests to extend information gathering needs to be considered in light of the precise form and focus of the SAR, and approach agreed? 5. Do you have adequate expertise in research methods and/or quality improvement to have oversight of plans and progress of information gathering for this SAR? Those conducting the review 1. Will the types of information and input you are seeking allow the SAR to fulfil its purpose (QM4) of illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities?	

		2. Are you clear what kind of data you are seeking from the different sources of information, and from different contributors to the SAR? 3. Where others are supporting you, have you enabled them to understand what kind of information they are looking for from different sources, be it people or paperwork? 4. Have all avenues and sources of information and input been considered to cover the range of relevant positions and perspectives, including all parts of multi-agency configurations, both operational and strategic angles? 5. Is there sufficient clarity about the methodological purpose of any plans to gather practitioners together, specifically about the kind of data they are able to provide and by what means it is going to be sought during the meeting? 6. Is there clarity about what kind of input needs to be sought from the person, where it is possible, and others significant to them? 7. Have all requirements regarding the processing of personal data been fulfilled in accordance with the current UK Data Protection Legislation and associated	

		regulations including: Data Protection Act 2018, UK General Data Protection Regulation ("UKGDPR") and The Privacy and Electronic Communications (EC Directive) Regulations 2003? Those providing practical support 1. Are you clear as to the range of information that needs to be assembled given the commission of this particular SAR and what arrangements are needed to support input from different individuals and groups of people? 2. Have the methods of gathering information in this SAR been documented? 3. Has guidance been provided to participating agencies and divisions about what information is requested at the beginning of the review, and the level of detail required, and why? 4. Where initial information gathering has taken place to support decision making about the referral, is there clarity about what additional information is needed to reflect the precise form and focus of the SAR (QM5)? 5. Has access been arranged for the reviewer(s) and relevant others to all	

		the different sources of information and input deemed relevant?	
10. Practitioners Involvement	The Safeguarding Adult Review (SAR) enables practitioners and managers to have a constructive experience of taking part in the review.	Those with ultimate accountability 1. Have you communicated directly with practitioners invited to participate in the SAR, stressing the importance of their input, acknowledging their possible fears, clarifying the support that will be available, and the intention of creating a constructive and valuable experience for them? 2. Are you planning to attend any of the practitioner events in whole or part, to reiterate your messages about the value of an open learning culture and the importance of their being able to 'tell it like it is'? 3. Are there arrangements for the Chair to write to thank practitioners personally for their involvement once the SAR is completed? Those with delegated responsibility 1. Have the right practitioners and managers been identified to contribute given the precise form, focus and approach that has been agreed for this SAR? 2. Have arrangements been made to secure the endorsement of leaders and managers in each agency and	

		profession of their staffs' engagement, and to achieve the relevant support and protections for individuals contributing? 3. Has an adequate duty of care to all participants to be involved in this SAR been secured? Those conducting the review 1. Is the purpose of practitioners' input clear, and understood by everyone, including that gained through interviews, conversations, meetings or events? 2. Are participants being provided with clear information about this SAR and their role in it? 3. Are agencies encouraging their staff to contribute their experiences and views to the SAR 'warts and all'? 4. Does the planning for the SAR include careful consideration of how to support all individual practitioners, including for example, those who played key roles in thecase, or those who are not part of core Safeguarding Adult Board (SAB) agencies, or are from agencies rarely involved in SARs? 5. Have you confirmed how all practitioners are being provided with adequate support and protections	

		within their own organisations to take part in the SAR process? 6. In your planning of group events, how have you considered the support and protection of all involved practitioners? 7. Has there been adequate consideration of whether there are any implications of the review for people now in senior management positions and if anything needs to be done to support them? Those providing practical support 1. Are participants being provided with clear information about the form and focus of this SAR and their role in it? 2. How will you gather feedback from participants about their involvement?	
11. Involvement of the person and relevant family members and network	The Safeguarding Adult Review (SAR) is informed by the person and relevant family and network members' knowledge and experiences relevant to the period under review.	Those with ultimate accountability 1. Has clear leadership been provided about the priority of enabling the person and relevant family and network members to contribute meaningfully to the SAR? 2. Is there a clearly documented and defensible decision process about who is invited to contribute to the SAR, how and the ways their input will inform the SAR, as well as a detailed rationale for anyone who has been excluded or declined?	

		3. Has the statutory requirement for early engagement with the individual, family and friends to agree how they wish to be involved, managing their expectations appropriately and sensitively, been sustained in this SAR regardless of its precise form and focus? Those with delegated responsibility 1. Has there been discussion about which family members should be invited to contribute and why, linked to the purpose of the SAR and the precise form, focus and approach? 2. When two or more families are involved, is there a clear, feasible plan for how the process will be managed? 3. Has it been agreed who is best positioned to have early discussions with the individual, family and friends to understand how they wish to be involved, how this fits with the form and focus of the SAR, and agree how best to enable them to contribute in a way that is meaningful to the learning? 4. Is there clarity about how the person and/or their family and networks will be able to influence the focus of the review?	

		5. Is there clarity about what the family is going to be asked and why? 6. Has there been discussion about how the analysis will be informed by family members' information, experiences and perspectives relevant to the form and focus of this SAR? 7. Is there clarity and agreement about how the person and their relevant family and network, and their input, are to be represented in the final report? 8. What are the mechanisms to allow the person and/or their family to provide feedback on the report before it is completed? 9. Do arrangements to feedback on drafts for the report balance the need for assurance about confidentiality until the report is signed off by the Board, and the value of trust and partnership with the individual and their family members? 10. Is there clarity and agreement, including with the reviewer(s), on any limitations regarding how individuals can be involved and influence this SAR? 11. Who in the network has appropriate experience and expertise to	

		communicate well with the person and family members at what may be an extremely difficult time, to best enable them to understand how to be involved, why it is important, to appreciate their expectations and manage any limits on their options clearly, kindly, sensitively and with respect? 12. Where there are criminal proceedings and family members are witnesses or suspects, has a discussion taken place with the police senior officer about the precise form and focus of the review, and the implications for when and how family members can be involved? Those conducting the review 1. Is there clarity about why the person, family members and/or friends are being involved in the SAR in terms of statutory requirements, methodological data needs and the principles of Making Safeguarding Personal? 2. Is there absolute clarity about the role/ identity from which any family member or friend is contributing, and the implications, especially where the person is still alive, for what information can be shared with	

		whom and where consent is required? Those providing practical support 1. How is sufficient continuity of communication with the individual and family members going to be sustained? For example, who will be the specific point of contact with the person and/or family members? 2. Are there adequate arrangements to support the person and/or members of their family and network through the process, including providing advocacy or another specialist support service where needed? 3. Have arrangements adequately considered relevant accessibility issues and the need for any reasonable adjustments?	
12. Analysis	The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on	Those with ultimate accountability 1. Are you championing the practical value of analysis that identifies what has led to and sustained the kind of practice problems or good practice that the case(s) reveals? 2. Are you building expectation at Board level of an analysis that seeks out causal factors and systems learning of relevance beyond the individual case or cases?	

	routine challenges and constraints to practitioner efforts to safeguard adults.	3. Are you managing expectations if the SAR is focused on exploring why progress had not been achieved against earlier learning, rather than a detailed analysis of the case referred for a SAR? Those with delegated responsibility *Analysing practice in a case or cases* 1. Is there adequate attention to detail and precision in presentation of the facts of the case and professional practice over the time period, to match the commission? 2. Has practice in the case been evaluated appropriately, identifying good practice and any shortfalls with reference to up-to-date research and the wider evidence base where this is helpful or necessary? 3. Does the assessment of practice in the case reflect the principles of Making Safeguarding Personal and the six core adult safeguarding principles? 4. Does the analysis explain why people did what they did in such a way that even incredible actions or inactions are comprehensible in the context of what people were trying to achieve, the challenges and constraints of their work	

		environment, as well as social and cultural aspects of single, multi-agency and multi-professional working? 5. Has the analysis of causal factors and efforts to untangle systemic risks been conducted with reference to up-to-date research and wider evidence base on safety science and 'human factors' that underpin a 'systems approach' to learning from practice and incidents? 6. Has the analysis clarified whether practice issues were unique to the case(s) and context or emblematic of wider issues and whether the factors that influenced were anomalies or systemic? 7. Where required in the commission has the analysis detailed the current relevance of past practice issues and their systemic conditions? 8. Where reference is made to practice beyond the case, either at the time of the case or in the present, is it clear where the knowledge about the wider safeguarding system has come from? 9. Does the analysis have clear conclusions and show clearly how the conclusions relate to the case(s),	

		as well as why they are relevant to wider safeguarding practice? *Progressing improvement activity* 10. Does the analysis identify and evidence what has or has not changed in relation to earlier learning? 11. Is there a causal analysis of what facilitated or obstructed progress? *Rigour and reliability of analysis* 12. Is there adequate detail and precision in the analysis relative to the size and scope of the SAR commissioned? 13. Is up-to-date research and the wider evidence-base about what constitutes good practice, being used in the analysis? 14. Is the causal analysis informed by, and referenced where appropriate, the evidence-base of safety science and human factors? 15. Is it clear what specific techniques have been used to minimise the bias of hindsight and knowledge of the outcome, on the analysis? 16. Does the presentation of the analysis show the working-out process adequately, allowing the interpretation to be critiqued and	

		counter evidence to be brought to bear? 17. Does the lead reviewer(s) access supervision or peer challenge to support the quality of analysis undertaken? Those conducting the review 1. Are the principles of Making Safeguarding Personal and the six core safeguarding principles reflected in your evaluation of safeguarding practice in the case(s)? 2. Are you sustaining a determined curiosity to take your analysis beyond commenting on compliance with relevant procedures, to providing explanations of professional behaviour that call on a range of social/cultural and organisational factors? 3. What approaches have you used to ward against only a partial use of information and input assembled for this SAR? 4. Is your analysis moving from the specific to the generalizable, identifying what professional activity in the case(s) reveals about how service delivery routinely worked at the time and why, and clarifying the	

		nature of systemic risks that remain today? 5. In your analysis, are you balancing practice expertise with expertise in human factors and safety science to support a rigorous interrogation of causal factors? 6. Have you considered the full range of research evidence, practice knowledge, guidance and theory, statute, national policy, other SARs and inspection reports that might be referenced in order to articulate the underpinning knowledge base relevant to your analysis?	
13. The Report	The report identifies clearly and succinctly the analysis and findings of the Safeguarding Adult Review (SAR), while keeping details of the person to a minimum. Findings reflect the causal factors and systems learning the analysis has evidenced.	Those with ultimate accountability 1. Has the report achieved the agreed commissioning specification? 2. Have you sought to manage expectations of all Board members regarding the proportionality of the SAR including the report? 3. Does it provide insights into factors that increase the risk that people will not be effectively safeguarded and/or illuminate conditions that are effective in enabling good safeguarding practice? 4. Are the findings that the SAB is asked to accept, and partners be	

		responsible for acting on, presented clearly and succinctly? 5. Can you and partners readily use the contents of the report to inform work to enhance partnership working, improve outcomes for adults and families and improve the reliability of efforts to safeguard adults in the future? 6. Are you assured that individuals and agencies involved have been given the opportunity to comment on the factual accuracy of details contained in the report? 7. Are you assured that any disputes, in particular regarding inaccurate factual analysis, alleged breaches of personal information, negligent misstatements and defamation have been addressed in line with relevant SAB guidance and governance processes? (This issue is picked up again in QM 14 on Publication and dissemination.) Those with delegated responsibility 1. Does the report get beyond description and foreground deeper analysis about social and organisational conditions that help or hinder effective, personalised safeguarding?	

		2. Does the structure of the report make it straightforward to distinguish any evaluation of the case from generalizable systemic issues deemed a priority for improvement? 3. Is there adequate transparency in how the conclusions have been reached? 4. Is the detail provided about barriers or enablers to good practice, and systemic risks specific enough to allow them to be shared and compared with findings from other SARs? 5. Has everyone involved, including the person and family had adequate opportunity to comment on the Final Draft Report and all comments, queries or disputes been addressed? 6. Does the report adequately manage accessibility and explaining complex professional and organisational issues? 7. Is the Report formatted clearly, in plain English, with any opinions or quotes attributed to their owners and referenced? 8. Is it clear in the report how views of the person and family members have been incorporated into the analysis, where appropriate?	

		9. Is the tone and choice of words appropriate to the review? 10. Does the amount of detail included about the person and the story of the case match what has been agreed, with input from the person and/or family themselves? 11. Has all the data to be routinely collected (administrative data; SAR characteristics; case characteristics) been detailed in the preferred format of the SAB and appropriate for this particular SAR, be that in the report or via a centralized SAB data base or spreadsheet? 12. Have you made it clear that the Final Draft Report is confidential, and not for distribution or public comment until the proposed publication date? Those conducting the review 1. Are you focused on producing a report that is succinct, accessible and useful to supporting improvements? 2. Have you distinguished case findings and presented clearly your systems findings that explain particular practice problems which featured in the case and represent wider learning about enablers or barriers to good practice?	

		3. Have you evidenced the barriers or enablers to good practice as strongly and with as much specificity as possible, given the range of data available to you? 4. Have you avoided the temptation to articulate solutions to address the systems findings when these depend on factors and constraints outside the scope of the SAR? 5. Have you included details of the person and events of the case as agreed, in such a way that they do not detract from the systems learning in the report about causal factors that help or hinder practitioners doing their jobs to optimum effect? 6. Have you presented complex issues as straightforwardly as possible without over-simplifying them? 7. Are you assured that all administrative data, SAR and case characteristics have been documented, if they are not included in the report? Those providing practical support 1. Have editorial arrangements been agreed? 2. Have you reminded people to cross-reference the report with the commissioning specification?	

		3. Have adequate arrangements been made to enable the person and/or family to convey whether or how they want to feature in the report	
14. Publication and dissemination	Publication and dissemination activities are timely and publicise the key systemic risks identified through the SAR	Those with ultimate accountability 1. Are genuine efforts being made to publish the SAR report as soon as possible and are any delays justified? 2. Have the wishes of and impact on the person, their family members and other families affected by the issues raised by this SAR been taken into account in all plans, and are they being supported well? 3. Are you satisfied that dissemination plans engage all the right audiences given the learning of this SAR, in compelling and engaging ways? 4. Do publication and dissemination plans reflect clearly and confidently the statutory functions and duties of the SAB? 5. Are you assured that any legal issues which may arise from publication have been identified and plans put in place to manage these? 6. Does the communications plan secure the right level of engagement from senior leaders of all relevant partners, regionally and nationally?	

		Has active engagement with the media been considered? Those with delegated responsibility 1. Is the report as anonymized as possible so that no individual can be identified through the contents, unless it has been explicitly agreed with the person themselves of their relevant family members to identify them? 2. Has the Final Draft Report been checked to identify any risk of legal challenge? For example, containing libellous content, conveying any civil or criminal liability, referencing law breaking or breach of professional standards which has not been already managed. 3. Have any potential points of disputes or litigation been identified? If so, have you alerted the accountable bodies and formulated a plan to manage this? 4. Do you need to alert the appropriate Legal departments? 5. Have you drawn up a media strategy and communications plan which considers the timing of publication, prepares press statements in advance and advises interested parties, including Chief Officers and	

		Boards of organisations involved, of imminent publication? 6. Are the professionals directly involved being informed of the contents of the report, of the schedule for publication and being given appropriate support? 7. When will the family have the report and are they being given appropriate support regarding its publication? 8. Are all those who have a responsibility in addressing issues raised in the SAR, included in dissemination plans? Has adequate consideration been given to disseminating 'up' to strategic leads in relevant organisations locally, regionally and nationally? 9. Have the additional products and mediums and activities needed from this SAR for different audiences been discussed and agreed? Do they add up to a compelling and engaging means of circulating the findings? 10. Is the learning being made as accessible as possible to all relevant audiences through the range of products and extent of dissemination and engagement plans? How well are they designed to foster active responsibility for addressing	

		systemic issues identified in the SAR? Those conducting the review 1. Are you satisfied that any questions or concerns raised have been addressed and that there are no risks of legal challenge that have not yet been identified? 2. Are you satisfied that your report does not contain libellous material and that any third-party information has been verified or the third party been given a right to comment? 3. Where a living person is identified, have you given duties under the Data Protection Act (DPA) 2018 very careful consideration? 4. Have you had the opportunity to influence and/or comment on any additional products to check they accurately reflect the findings of the SAR report? Those providing practical support 1. Is legal advice necessary to inform decisions about publication? 2. Have relevant champions, forums and/or networks been identified that can support dissemination to the range of different audiences?	
15. Improvement actions and	Improvement actions agreed in	Those with ultimate accountability	

evaluation of impact	response to the SAR set ambitious goals, seeking to align the motivations of different stakeholders, bringing partners together in new ways and foster collaborative working.	1. Have you provided clear leadership about the need for an open and mutually challenging discussion about what is said in the report about the effectiveness of safeguarding arrangements and practice, or progress against earlier learning, and what needs to be done to address systemic risks identified or progress improvement work? 2. What part might the person and family subject of this SAR, and people with relevant lived experience and/or who draw on services more widely, have in this process of deciding actions and evaluation planning? 3. How can you bolster partners toward suitably ambitious goals? 4. Is specialist support or facilitation needed in the effort to align motivations and think beyond conventional responses and partnership arrangements? 5. Have discussions considered which findings may NOT be within the gift of partners locally to address, but instead need to be taken to national, regional or other forums for consideration of how best to address them?	

		6. Are proposed actions adequately integrated, where appropriate, into on-going or planned workstreams / priority areas of the SAB and/or partner agencies, regional or national bodies? 7. Are you assured that relevant agencies and sectors have the necessary mechanisms to link the SAR findings into improvement work as agreed and evaluation of impact and if not, what sources of support are available? 8. Has a logic model or similar technique been used to articulate to the SAB the intended impact and outcomes of proposed actions, for whom, in what timescales and by what mechanisms? 9. Are SAB expectations clear about plans for longer-term monitoring of improvement actions and follow up to evaluate impact? 10. Is there agreement about whether follow-up on impact best occurs locally or at a regional or sub-regional level? 11. Does reporting in the Board's Annual Report comply with statutory requirements and provide genuine transparency and accountability about whether improvement actions	

		have taken place and whether they have made any difference? Those with delegated responsibility 1. Do the proposed responses by agencies and the SAB genuinely tackle the systemic risks identified by the SAR and at the right levels of a system hierarchy, and avoid assuming that disseminating SAR outputs to operational staff is adequate? 2. Are you using a model for change management or 'organisational development' to help think wider than changes to procedures and training for staff? 3. Have you considered who is best placed to decide what an effective response to each of the findings would be, and how to engage them in these discussions? 4. Have any ‘quick wins’ been identified, and distinguished from causal factors and conditions that are less straightforward to address? 5. Is there a clear plan of how the SAB will monitor whether actions are on track?	

		6. Does the plan to evaluate impact match the theory of change for each finding? 7. Will a Task and Finish Group be needed to manage and monitor progress, particularly if there are numerous points to the Plan and if several organisations are involved and responsible for different aspects. Those providing practical support 1. Can you help with making accessible intelligence from other sources that is relevant to findings in the report? 2. Has a clear, considered process been planned, to avoid a last-minute rush to agree responses? 3. Are any key players missing from this process and how can they best be engaged? 4. If developing an action plan is being left to you to create in isolation, have you escalated the issues	

APPENDIX I: INDIVIDUAL MANAGEMENT REVIEWS (IMRs) TEMPLATE

Prior to the Safeguarding Adults Review starting a meeting will be arranged with the Safeguarding Adults Review Panel and all IMR Authors to go through the process and expectations of the Individual Management Review.

This document is intended to provide an IMR of the decisions, actions taken and services provided to the adult.

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 officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

The IMR brings together and draws overall conclusions from the involvement of the agency with the vulnerable adult.

Name of Agency:

Name of Adult(s):

DOB/DOD:

Name, agency and contact details of person completing chronology and individual management review (IMR):

Date of Request for IMR:

Date of Completion of IMR:

Terms of Reference (to be appended):

FACTUAL/CONTEXTUAL SUMMARY

Provide a brief factual and contextual summary of your agency's involvement with the vulnerable adult for the time period identified for this safeguarding adult review.

CHRONOLOGY OF AGENCY INVOLVEMENT

(To be completed on the chronology template provided).

Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the adult(s) and/or alleged perpetrator over the period of time set out in the review's terms of reference. Where abbreviations are used, please provide a glossary at the back of this document to explain them.

ANALYSIS OF INVOLVEMENT

The report author is expected to rigorously analyse the involvement of their agency. 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. The Terms of Reference should be referred to as headings to analyse practice against. Facts should not be stated without their origin. Consider specifically:

- Were practitioners sensitive to the needs of the adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a concern about an adult at risk?
- Did the agency have in place policies and procedures for safeguarding adults at risk and acting on concerns about abuse or neglect?
- What were the key relevant points/opportunities for assessment and decision making in the case in relation to the adult? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did action accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?
- Where relevant were appropriate care plans in place, reviewing processes complied with and how did they involve relevant risk assessment in protecting the adult?
- Were more senior managers or other agencies and professionals involved at points they should have been?
- Was the work in this case consistent with agency policy and procedures for safeguarding adults, and wider professional standards?
- Was mental capacity considered and any formal Mental Capacity Assessment recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult? Cite ethnicity and culture of the vulnerable adult and the relevance of this to provide an exploration.
- Were relevant, appropriate safeguarding adults or care plans in place, and safeguarding adults reviewing processes complied with?
- Are there are any particular features of this case, or issues surrounding the death or harm to the adult(s), that you consider require further comment in respect of your agency's involvement?

LEARNING

- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there lessons from this case for the way in which this agency works to safeguard adults?
- Are there implications for ways of working?
- Are there implications for management and/or supervision?
- Are there implications for training (single or multi-agency)?

RECOMMENDATIONS FOR ACTION

Recommendations should be few in number, focused and specific, and capable of being implemented. Consideration should be given to the resources required to implementing the recommendations such as cost.

IMR ACTION PLAN FOR SAFEGUARDING ADULTS REVIEW (Insert Agency/Organisation name here)						
No.	What is the recommendation? (This should be lifted directly from the IMR)	What is the desired Aim / Outcome? What do we want to achieve?	How will change be achieved? What are the actions that need to take place?	Leadership Who will chase progress and be responsible for completion of the action?	Timescale By what date will the action be completed?	Outcome Measure How will you know what difference it has made? (for adults at risk)
1.						
2.						

APPENDIX J: CHRONOLOGY TEMPLATE

Date	Source of evidence	Contact with	Name of professional involved and role	Reason	Incident contact/location and type	Action taken/decision made/outcome	Comment

APPENDIX K: LETTER TO FAMILY TEMPLATE

Dear NAME

Safeguarding Adult Review re NAME

I am writing to you in my role of the Independent Overview Report Author commissioned by the Portsmouth Safeguarding Adults Board to write the Report for the above into the circumstances leading to your RELATIVE's death on DATE.

I have enclosed a brief leaflet about both the Portsmouth Safeguarding Adults Board and Safeguarding Adults Reviews for your information. The Care Act 2014 requires that a Safeguarding Adults Review must be commissioned when certain criteria are met, and it has been decided that your RELATIVE's situation met these criteria. The same Act and its supporting regulations recommend that the adult and their family should be invited to contribute to the Safeguarding Adult Review so that organisations can best learn how to improve the quality of their services in the future.

I would therefore like to meet with you to answer any questions you may have about what a Safeguarding Adults Review is and to help me understand your views and feelings on your experience of the services offered to you and your family. I would be happy to meet you at a mutually convenient time and venue, and if you wanted to have someone with you to support you, that would be fine. If you would rather speak on the telephone than meet, that would also be fine.

I hope you will feel able to contribute to the Review, but you are not obliged to do so; if you choose not to, you are free to change your mind in the future and I will be in contact again to keep you updated on the Review's progress and when my Report is nearly completed to discuss my findings and recommendations.

I would be grateful if you would contact NAME, the Board Manager on NUMBER to let me know whether or not you wish to contribute to the Review. NAME will be able to arrange any meetings between us.

Yours sincerely,

APPENDIX L: INFORMATION FOR FAMILIES

What is the Portsmouth Safeguarding Adults Board?
The Portsmouth Safeguarding Adults Board brings together the main organisations that work with adults at risk and their families across Portsmouth including Police, Health Trusts, Housing, Probation and Adult Services with the aim of making sure they work in partnership to keep adults at risk safe. Under the Care Act 2014, all local authorities are required to establish a Safeguarding Adults Board.

What is a Safeguarding Adult Review?
Safeguarding Adults Boards are required by the Care Act 2014 to carry out a Safeguarding Adult Review when an adult at risk in their area has been seriously harmed or has died and abuse or neglect is suspected and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future. Safeguarding Adult Reviews look at how local organisations have worked together to provide services to the adult(s) at risk who is/are subject to review. A Safeguarding Adult Review is completely separate from any investigation being undertaken by the Police or Coroner. It is not a means of apportioning blame or responsibility for what has happened.

Who undertakes Safeguarding Adult Reviews?
Safeguarding Adult Reviews are undertaken using different methods, involving people from the various organisations who were involved with the adult at risk. There will be a Chair and someone who is independent of the organisations involved in the Review is responsible for writing the final report, known as the Overview Report Author. At the end of the process the final report is produced which is agreed by the Safeguarding Adults Board.

How long will the review take?
The Review should be completed within 6 months of the decision being taken to start the Review. Sometimes this timescale needs to be extended.

How are families involved?
Families and, where relevant and appropriate, close friends and carers, will be given the opportunity to share their views and comment on the services they, and the adult at risk received. They will be contacted to offer to arrange a meeting by those undertaking the Review. When the Review is complete there will be a follow on meeting offered to outline the findings and recommendations and families will be provided with a copy of the Executive Summary prior to its publication. This will also be available on the Portsmouth Safeguarding Adults Board website.

Further information
If you want to know more about Safeguarding Adult Reviews the Safeguarding Adults Board Manager will be happy to be approached. Contact details:

APPENDIX M: EASY READ INFORMATION

Easy Read - Information leaflet

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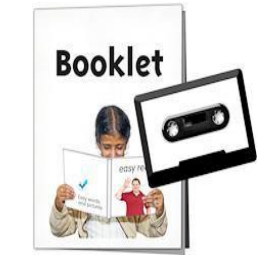
<tr>
<td> 

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<td>If you need this information given to you in a different way please contact the:

Adult Help Desk:
023 9268 0810.</td>
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<td>  </td>
<td>What is Portsmouth Safeguarding Adults Board (PSAB)?

Portsmouth Safeguarding Adults Board is a partnership of all the agencies who work with vulnerable adults and families in Portsmouth.

They work together to support vulnerable adults to stay safe.</td>
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<td>What is a Safeguarding Adult Review?

A Safeguarding Adult Review is when people look at how well local organisations have</td>
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 	worked together. The people doing the review look at what was done and how they can do things better in the future. They also look at what changes may need to be made to services. The safeguarding adult review is not a Criminal Investigation or a Public Enquiry. The people doing the review want to learn how to make things better and not to blame people.
 	**Why Are You Carrying Out a Safeguarding Adult Review?** Portsmouth Safeguarding Adults Board (PSAB) has to carry out a Safeguarding Adult Review when it is found that abuse or neglect has happened to an adult at risk who has been • seriously harmed or • When someone has died
	**Who Will Carry Out the Review?** The people who will do the review are staff from Adult social care in Portsmouth

	City Council, staff from the Health Service and staff from the Police and sometimes staff from other organisations.
	The review is run by an independent person. They are not part of any of the organisations that are involved in the review.
	Each organisation which has worked with or provided services for the person will write a report.
	The people carrying out the review will meet to look at reports from each organisation.
	After this meeting a report is prepared of everything that has been talked about and agreed.
	This report will say what everyone has learnt from this review and what is agreed that needs to be changed to make things better.
	These recommendations will be sent to Portsmouth Safeguarding Adults board.

How might I be asked to help?

You do not have to do anything.

If you would like to give your views you can choose to do this.

We will make sure that there is a personal contact who can help you to do this. The contact phone number is 023 92 847889, if you would like to ask for support.

What Happens after the Report is Finished?

When the report is finished the Portsmouth Safeguarding Adults Board will write an action plan to make sure changes are made to make things better.

These changes will help the organisations work together to support adults at risk to stay safe.

The organisations that have been involved in the review will also need to write an action plan.

Portsmouth Safeguarding Adults Board makes sure the actions happen and makes sure things work well.

Who Will See the Report?

The staff from the organisations on the PSAB will be shown the report.

The other staff who work in the organisations who worked with the adult and their family may also be shown the report.

The final report does not show any personal details or information about the person or the family involved in the review.

The Report is made available to anyone who wants to read it and is shown on our web site. www.portsmouthsab.uk/

Your personal contact will meet with you and tell you what is in the report before it goes on the website.

How Long Will the Review Take?

The review usually takes 6 to 9 months. This is from when the review starts to when the review ends which is when the report is written.

In this leaflet we have answered some of the questions families sometimes have about Safeguarding Adult Reviews.

You may have other questions you would like to ask. If you have any questions, you can call the Safeguarding Adults Board Manager on 023 92 847889.

Email address for Portsmouth Safeguarding Adults Services – PortsmouthAdultMASH@portsmouthcc.gov.uk