SAFEGUARDING ADULTS REVIEW POLICY & PROCEDURES

Version 5

Teeswide Safeguarding Adults Board

Contents **Page**

Change Record:

Revision Number	Date Approved by the Board	Change Record	Links to Other Policies	Review Date:
4.1	23-Jan-19 (SAR Sub-Group)	Emphasis on quality assurance and completing chronologies within specified timescales	All other Teeswide Safeguarding Adults Policies	Apr-20
5	11-Dec-19	Updated according to 'Legal considerations for SABs'	All other Teeswide Safeguarding Adults Policies	Dec-21

1. Introduction

Safeguarding is 'Everyone's Business'

The Teeswide Safeguarding Adults Board (TSAB) is the statutory body that sets the strategic direction for safeguarding and is responsible for protecting adults who are experiencing, or who are at risk of abuse or neglect living in the Boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees.

The Care Act 2014[1], which came into force in April 2015, created a new legal framework for Adult Safeguarding. This included outlining the circumstances in which Safeguarding Adults Boards (SABs) **must** arrange a Safeguarding Adults Review (SAR). The Care Act further placed a duty on all Board members to contribute to the undertaking of such reviews.

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. The Care and Support Statutory Guidance[2] issued under the Care Act by the Department of Health also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

The Teeswide Safeguarding Adults Board is committed to the values of honesty, openness, transparency and proactive learning in undertaking Safeguarding Adults Reviews.

2. Purpose

The purpose of this policy is to outline the principles and definitions that support the commissioning and undertaking of Safeguarding Adults Reviews and to describe the statutory duties set out under Section 44 of the Care Act 2014. This policy is supported by the Teeswide Inter-Agency Policy and Procedures and the individual policy and procedural guidance of each partner agency.

3. Scope

The safeguarding duties apply to any adult who:

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

This definition of adults at risk of abuse or neglect includes:

- those who are at a greater risk of suffering abuse or neglect because of physical, mental, sensory, learning or cognitive illnesses or disabilities; and substance misuse or brain injury
- those who purchase their care through personal budgets, those whose care is funded by local authorities and/or health services and those who fund their own care
- informal carers, family and friends who provide care on an unpaid basis.

4. Policy Statement

The Teeswide Safeguarding Adults Board works in partnership to safeguard and promote the well-being and independence of adults living in the Boroughs of Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees, who are experiencing, or at risk of abuse or neglect. It further seeks to examine lessons learned as a result of SARs undertaken both locally and nationally and to review and revise policies and procedures accordingly in order that it may assure itself of the protection of adults from either the risk of, or the experience of abuse or neglect.

[1] The Care Act 2014, Sections 42-46
[2] The Care and Support Statutory Guidance, Department of Health, 14.162 – 14.179

5. Legal Framework

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies **either** as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; **or** if an adult has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect. The Care Act also states that SABs 'are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.'

The Act further defines that 'something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.'

This policy has been developed within the context of the law and guidance that seeks to protect adults including:

- The Care Act 2014
- Care & Support Statutory Guidance
- The Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards)
- The Human Rights Act 1998
- The Equality Act 2010
- Mental Health Act 1983 and the Code of Practice 2015.

Further links to useful websites can be seen on page 10.

6. Information Sharing

The Care Act 2014, Section 45 creates a **legal duty** for any agency or person to share what they know with the Safeguarding Adults Board (SAB). The test is that the information requested by the SAB must be for the purpose of enabling or assisting it to perform its functions, including that of undertaking Safeguarding Adults Reviews. This means that if a SAB requests information from an organisation or individual who is likely to have information, which is relevant to the SAB's functions, they **must** share what they know with the SAB. Further details on information sharing locally can be found in the TSAB Multi-agency Information Sharing Agreement. Link

7. Who this Policy applies to

This policy applies to all partners of the Teeswide Safeguarding Adults Board who have collective responsibility for ensuring that the Board is able to meet its statutory duties. Specific detail of the partnership is outlined in the Teeswide Safeguarding Adults Board's Inter-agency Safeguarding Adults Policy.

8. Principles

This policy reflects the six safeguarding principles described in The Department of Health Care and Support Statutory Guidance issued under the Care Act 2014, that underpin all safeguarding adult work and which applies to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. These principles are as follows:

Empowerment	People being supported and encouraged to make their own decisions and informed consent. *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*

Prevention	It is better to take action before harm occurs. *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
Proportionality	The least intrusive response appropriate to the risk presented. *"I am sure that the professionals will work in my interest, as I see them and they will only be involved as much as needed."*
Protection	Support and representation for those in greatest need. *"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. *"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."*
Accountability	Accountability and transparency in delivering safeguarding. *"I understand the role of everyone involved in my life and so do they."*

In addition the Care and Support Statutory Guidance outlines a number of principles to be followed by Safeguarding Adults Boards and their partner organisations when undertaking Safeguarding Adults Reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the well-being and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the level of complexity of the issues being examined
- reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

9. Key Roles and Responsibilities

The Independent Chair of the Teeswide Safeguarding Adults Board

The Independent Chair has responsibility for:

- ensuring that the Teeswide Safeguarding Adults Board meets its statutory responsibilities and reports on the discharge of its functions
- making a decision in response to any recommendation for a Safeguarding Adults Review by the Teeswide Safeguarding Adults Board SAR Sub-group
- appointing suitable independent individuals to lead the SAR. The roles to be undertaken will be dependent on the methodology to be used but may include a Lead Reviewer or Reviewers, an Independent Chair Person, and an Independent Author. People should have the required level of objectivity to ensure openness and transparency
- considering whether an outside expert should be consulted to help understand any specific aspects of the case
- agreeing the scope, terms of reference, methodology and funding for the SAR.

Teeswide Safeguarding Adults Board
The Teeswide Safeguarding Adults Board has responsibility for:

- identifying appropriate individuals from their own agencies to be involved in the process
- receiving/considering regular reports on progress from the SAR sub-group
- considering final review reports
- agreeing the process for dissemination of the review
- agreeing and ensuring that multi-agency action plans resulting from SARs and other forms of review are implemented.

Safeguarding Adults Review Sub-Group
The Safeguarding Adults Review Sub-group has responsibility for:

- considering all SAR notifications
- fulfilling the statutory duty of the Teeswide Safeguarding Adults Board in respect of Safeguarding Adults Reviews and ensuring that SARs are completed in line with the SAR Policy and Procedure
- making recommendations to the TSAB Independent Chair on the appropriate type of case review and where responsibility rests for leadership, oversight and co-ordination of the chosen review process
- making recommendations about **how** the ***adult*** and/or their representative should be involved including whether or not they need an advocate
- performance managing the SAR process
- ensuring that the reports from all reviews, together with a recommendation on action planning, are presented to the TSAB for approval
- regularly reporting progress against the agreed action plans to the TSAB
- working closely with the relevant Sub-Groups to ensure that any recommendations from a review are fully implemented
- ensuring that any lessons learned from local, regional, and where appropriate, national SARs and other forms of review are disseminated throughout the TSAB partner agencies.

Safeguarding Adults Review Panel
The Safeguarding Adults Review Panel has responsibility for:

- undertaking the SAR in accordance with the agreed scope, terms of reference and methodology
- considering how the interfaces between other reviews/proceedings should be managed in order to maximise learning for individuals and organisations, and to avoid duplication for families and professionals
- considering how the review process should take account of previous lessons learned both nationally and regionally
- ensuring appropriate involvement of professionals and organisations that were involved with the adult
- considering if the Review Panel will need to obtain independent legal advice about any aspect of the review
- considering how to liaise with the adult and/or their representative
- completing the final report with recommendations and action plans
- presenting the final report to the Teeswide Safeguarding Adults Board.

10. Involvement of the Adult, Family Member and Friends

Discussion should take place at an early stage with the ***adult*** and/or their representative to agree **how** they wish to be involved in the process, using the principles of Making Safeguarding Personal (MSP). Where the ***adult*** has mental capacity, the involvement of family, friends or informal carers should be agreed with the adult. In any case where the ***adult*** does not have mental capacity; family, friends or informal carers must be consulted in accordance with the Mental Capacity Act

2005. The Local Authority has **a duty** to involve an appropriate person to facilitate an adult's involvement in the safeguarding adult process if it is deemed that they would have substantial difficulty in participating themselves.

Advocacy

As part of the safeguarding adult procedure, consideration must be given as to whether the ***adult*** may benefit from the support of an independent advocate. Where the adult has substantial difficulty in participating in the safeguarding adult process, and there is no other appropriate person to assist them, the Local Authority must arrange that independent advocacy. Where an Independent advocate has already been arranged under Section 67 of the Care Act 2014, or under the Mental Capacity Act 2005, the same advocate should be used unless for good reason, this is deemed to be inappropriate.

11. The Coroner

Consideration should be given to undertaking a Safeguarding Adults Review if the Coroner contacts the Teeswide Safeguarding Adults Board with specific questions arising from the death of an adult at risk in any of the following situations:

- where there is an obvious and serious failing by one or more organisations
- where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
- where a death has occurred and there are concerns for others in the same household or other setting (such as a care home) or:
- deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.

In any situation where the Teeswide Safeguarding Adults Board determines not to undertake a Safeguarding Adults Review following contact by the Coroner, the reasons for this should be recorded and the Coroner informed.

12. Links to Other Reviews/Proceedings

When SARs overlap with other statutory review processes such as a Children's Serious Case Review, Multi Agency Public Protection Arrangements (MAPPA) Review or Serious Case Review, Domestic Homicide Review (DHR), Mental Health Homicide Review or Serious Incident Review, the chairs of the respective review processes should formally discuss and consider how the interfaces between these should be managed in order to maximise learning for individuals and organisations, and to avoid duplication for families and professionals.

Consideration should be given as to whether:

- all aspects of the case could effectively be covered by one of the reviews or;
- some aspects of related reviews commissioned or undertaken jointly ensuring that the Terms of Reference effectively cover all aspects of the case
- it would be appropriate for related reviews to be chaired by the same person.

Early consideration should also be given as to how the Safeguarding Adults Review will take account of other significant processes such as:

- Police investigation/criminal charges.
- Coroner's inquest
- Health and Safety Executive investigation/charges.

In such circumstances the TSAB Independent Chair should seek advice from the police and the CPS, if appropriate, on how the Safeguarding Adults Review should take account of any criminal investigation or proceedings. They should also establish what potential impact a Safeguarding Adults Review may have upon such investigations or proceedings, including whether a SAR should not start until after the proceedings are completed or, if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings.

Children's Serious Case Review (SCR)
Local Safeguarding Children Procedures apply to young people who are under the age of 18. A Serious Case Review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. A SCR should take place if abuse or neglect is known, or suspected to have been involved and:

- a child has died or a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child
- the child dies in custody
- a child died by suspected suicide.

The Hartlepool & Stockton Safeguarding Children partnership and the South Tees Safeguarding Children Partnership follow statutory guidance for conducting SCRs. More information can be found at:

- Hartlepool & Stockton Safeguarding Children Partnership
- South Tees Safeguarding Children Partnership

Multi Agency Public Protection Arrangements (MAPPA) Review or Serious Case Review
Inter-Agency Public Protection Arrangements[3] are a set of arrangements to manage risk posed by the most serious sexual and violent offenders under the provisions of the Criminal Justice Act 2003. They bring together the Police, Probation and Prison Services into MAPPA responsible authorities. A number of other agencies are under a duty to co-operate (DTC) with the responsible authority including Social Services and Health Trusts.

The purpose of the MAPPA SCR is to look objectively and critically at whether MAPP arrangements were effectively applied. A MAPPA SCR must be commissioned if both of the following conditions apply:

- the MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed
- the offence is murder, attempted murder, manslaughter, rape or attempted rape.

Domestic Homicide Review (DHR)
A Domestic Homicide Review incorporates a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself with a view to identifying the lessons to be learned from the death.

Statutory guidance[4] has been issued by the Home Office under section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

Mental Health Homicide Review
NHS England is responsible for commissioning independent investigations into homicides that are committed by patients being treated for mental illness[5]. The purpose of the investigation is to review thoroughly the care and treatment received by the patient so that the NHS can:

- be clear about what, if anything, went wrong with the care of the patient
- minimise the possibility of a reoccurrence of similar events
- make recommendations for the delivery of health services in the future.

The review is carried out separately from any police, legal or Coroner's proceedings. A final report is prepared as part of the investigation process which is shared with the NHS organisations that

[3] MAPPA Guidance 2012 (version 4)
[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office
[5] Serious Incident Framework, supporting learning to prevent recurrence, NHS England

were responsible for the care of the patient, together with the families of the victim and the patient. The NHS organisations involved are required to produce a plan that clearly sets out the actions they will take in response to the report from the investigation.

Serious Incident Review

The NHS Commissioning Board (NHSCB) is responsible for patient safety in relation to NHS funded services and care and all Serious Incidents (SI's) have to be reported to the NHSCB. A Serious Incident is defined as an adverse event or circumstances that occurred which resulted in:

- unexpected or avoidable death
- serious harm to one or more patients, staff, visitors or members of the public
- a provider's inability to continue to deliver healthcare services
- allegations of abuse
- adverse media coverage
- one of a core set of 'Never Events' (defined as serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers).

The Revised Serious Incident Framework[6] published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. The framework acknowledges the increasing importance of taking a whole-system approach to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again.

13. Duty of Candour

Secondary Care Providers registered with the Care Quality Commission are subject to a statutory Duty of Candour when they are carrying on a regulated activity (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20).[7] The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The Teeswide Safeguarding Adults Board is committed to the principles outlined in the Duty of Candour when undertaking all Safeguarding activity.

14. Timescale

The Teeswide Safeguarding Adults Board is committed to completing Safeguarding Adults Reviews in a timely manner and 'in any event, within six months of initiating it unless there are good reasons for a longer period being required[8].' This could include for example, the need to delay the process due to legal proceedings or to any relevant circumstances surrounding the adult.

15. Findings from Safeguarding Adults Reviews

In accordance with the Care and Support Statutory Guidance, all Safeguarding Adult Review Reports 'should be written in plain and easy to understand language, provide a sound analysis of what happened and why; and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence.'

All Safeguarding Adults Reviews conducted within the year must be referenced within the Teeswide Safeguarding Adults Board's Annual Report together with any actions that it has taken or intends to take. The Annual Report must also include the reason for any decision where the TSAB decides not to implement an action. The reviews must be anonymised and meet the statutory requirements outlined in the Care Act 2014.

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[6] Serious Incident Framework, supporting learning to prevent recurrence, NHS England
[7] Care Quality Commission, Regulation 20: Duty of Candour
[8] The Care and Support Statutory Guidance, Department of Health, 14.144

The Teeswide Safeguarding Adults Board will consider publishing Safeguarding Adults Reviews, together with associated action plans on their website. The Board retains discretion over the process and timing of the publishing taking into account any mitigating factors e.g. ongoing criminal investigations. The Board will consider sharing the findings and lessons learned from any SARs with Local Safeguarding Children Partnerships on an individual basis.

The Teeswide Safeguarding Adults Board will retain the intellectual property rights in relation to all reviews undertaken.

16. Links to Other Websites

- Safeguarding Adults Reviews under the Care Act: SCIE: Safeguarding Adult reviews
- ADASS: Safeguarding Adults
- Crown Prosecution Service: legal guidance on carrying out reviews

17. Safeguarding Adults Review Procedures - Introduction

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area:

1. dies **either** as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult;

Or

2. if an adult has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care Act also states that SABs 'are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.'

The adult experiencing abuse or neglect will be referred to as the ***adult*** throughout this procedure. The ***adult*** and/or their representative should be kept informed as described within both sets of procedures.

18. Safeguarding Adults Review Decision Making Procedure

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
1	**Notification**	1. Notifications for consideration of a Safeguarding Adults Review should be made to the TSAB Business Unit using form SAR 01.	Referrer	In a timely manner and as soon as is reasonably practicable.
		Notifications (SAR 01) must be fully completed, include relevant and factual information, provide contact details for all agencies involved and be signed and dated by the referrer.	Referrer	
		Notifications must be quality checked and screened by the TSAB member or a designated Senior Manager.	TSAB Member	
		Wherever possible notifications should be forwarded by the agency's TSAB member. Where notifications are not forwarded by the agency's TSAB member, the Business Unit will ensure that the TSAB member has been informed of the notification.	TSAB Member Business Unit	
		Notifications from non-board member agencies should also be made to the Business Unit. The referrer will be asked to complete form SAR 01 if they have not already done so.		
		If a family member wishes to submit a notification for consideration, then they should submit their request in writing to the Independent Chair who will liaise to request a formal notification is submitted.	Independent Chair	
		Upon receipt of a notification, the Business Unit will: a) Confirm receipt of form SAR 01 to the relevant TSAB member and/or referrer b) Screen the information received against the TSAB SAR Policy, SAR Decision Support Guidance and the DH Care and Support Statutory Guidance; and inform the TSAB Independent Chair if the criteria appears to be met c) Inform the referrer if the criteria is not met	 Business Unit Business Manager Business Manager	Same day as the notification is received Same day as the notification is received As above
		2. The ***adult*** and/or their representative <u>will only</u> be informed at this stage of the process if there *are exceptional circumstances.*	SAR Sub-Group Chair/Business Manager/relevant Local Authority	
		3. All appropriate agencies should be invited to attend the meeting including the referrer (using the information outlined on form SAR 01). This may be in **addition** to those agencies that are	TSAB Independent Chair/Business Manager	

		established members of the SAR Sub-Group.		
		4. Agencies will be sent a copy of the completed SAR01 and asked to complete an Initial Chronology Form SAR02, outlining their involvement with the individual between specified dates. A clear deadline for returning the initial chronology will be given.	Business Unit	Within 3 days of receipt of the SAR 01
		5. At least three agencies should be represented at the meeting including the notifying agency (referrer) and the local authority in which the ***adult*** is/was normally resident.	SAR Sub-Group	
		6. The Chair of the SAR Sub-Group Meeting should be independent of the referring agency and the local authority where the ***adult*** is/was normally resident. This may be different from the normal Chair of the SAR Sub-Group *(see SAR Sub-group Terms of Reference)*.	TSAB Independent Chair/Business Manager	
		7. The TSAB Independent Chair should be advised of the date of the meeting. It is not expected that the TSAB Independent Chair will be in attendance at these meetings unless it is deemed to be necessary.	Business Unit	
		8. The SAR 01 will not be considered by the SAR Sub-Group until all initial chronologies have been received. If there are significant delays the Business Unit will escalate to the Independent Chair.	Business Unit	
2	**Decision Making**	1. The information contained on the notification and initial chronologies should be considered by the SAR Sub-Group and a decision made using the TSAB SAR Policy, TSAB SAR Decision Support Guidance and the DH Care and Support Statutory Guidance, as to whether: a) The criteria for a SAR are met or whether more information is required b) The criteria are not met but another type of review would be appropriate c) The criteria are not met and no further action is to be taken	SAR Sub-Group Chair/Sub-Group attendees	Within 28 days of the notification
		2. The SAR Sub-Group should also take into account: a) Whether any other Statutory Review Processes are taking place (Children's SCR, MAPPA SCR etc.) b) Whether any other significant processes are taking place (Police Investigation, Coroner's Inquest, HSE Investigation)	SAR Sub-Group Chair/Sub-Group attendees	Within 28 days of the notification

		c) What potential impact a SAR may have upon such investigations or proceedings, including whether a SAR should not start until after the proceedings are completed or, if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings d) If there is a delay in the commencement of a SAR, then the SAR Sub-Group Chair will ensure that any learning at this stage of the process is identified and shared with relevant parties.		
		3. If the criteria are not met, but another type of case review is felt to be appropriate, the SAR Sub-group should recommend which type of review would maximise learning. Other types of review **may** include a Lessons Learned Review, Management Review or Single Agency Review; or a Reflective Practice Session. This list is **not** exhaustive.	SAR Sub-Group Chair/Sub-Group attendees	
		4. Where another type of review takes place the TSAB will receive a report on the findings and any recommendations made.	Relevant TSAB Member	Within 6 months of the review being initiated
		5. The scope of the SAR should be clarified to include sufficient information to enable participating organisations to prepare for the first SAR Governance Group meeting. The scope of the SAR will also determine the timeframe during which events in the ***adult's*** life will be reviewed, taking into account the circumstances of the case.	SAR Sub-Group	
		6. The SAR Sub-Group should recommend to the TSAB Independent Chair a suitable lead for the SAR Governance Group.	SAR Sub-Group	
		7. The SAR Sub-Group meeting should use its collective knowledge and experience to recommend to the TSAB Independent Chair the most appropriate learning method for the case. There is a range of methodology options for conducting Safeguarding Adults Reviews. Guidance on this from the Social Care Institute for Excellence can be found at http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/ *This guidance is not exhaustive and other methodologies or a hybrid of such can be used.	SAR Sub-Group	
		8. The TSAB Independent Chair should be verbally advised of the recommendation, which will then be confirmed in writing using the SAR	SAR Sub-Group Chair/Business Chair	Within 2 working days of the SAR 01 being considered

		summary sheet SAR 03. *This will include the scope of the SAR and suggested methodology.*		
		9. The final decision to conduct a SAR rests with the TSAB Independent Chair. The Chair may wish to seek peer challenge from another SAB Chair when considering this decision.	TSAB Independent Chair	
		10. In the event of the TSAB Chair disagreeing with the recommendation that the criteria for a SAR are met, further discussions should take place between the TSAB Chair and the SAR Sub-group Chair to establish a way forward. This could include commissioning a different type of case review (see 3 above).	TSAB Independent Chair/SAR Sub-Group Chair	Within 5 working days of the SAR 01 being considered
		11. The referring agency/person to be informed of the decision.	Business Unit	Within 5 working days of the recommendation being agreed.
		12. Discussions should be held on **how** to inform the **adult** and/or their representative if <u>there is to be a SAR.</u> This should be confirmed in writing, and leaflet SAR 04 used in line with 4.3 below. Otherwise the **adult** and/or their representative will not to be informed if <u>there is not going to be a SAR</u> unless there are *exceptional circumstances* (see section 1.2)	Relevant Local Authority/Business Unit	
		13. The funding for the SAR/other type of review will be identified, agreed and appropriate commissioning arrangements put in place.	TSAB Independent Chair/Relevant Local Authority	
3	**SAR Governance Group**	1. Suitable independent individuals should be appointed to lead the SAR. The roles to be undertaken will be dependent on the methodology to be used, but may include: a) A Lead Reviewer (or Reviewers) b) An Independent Chair c) An Independent Author for the SAR Overview Report d) SAR Sub-Group members Consideration should be given to updating Board members if there is a significant amount of time between the initial SAR Sub-Group meeting and next TSAB Board meeting.	TSAB Independent Chair/relevant Local Authority	Within 28 days of notification
		2. All members of the SAR Governance Group should be experienced and suitably qualified to contribute fully to the process.	TSAB Independent Chair/TSAB Members	
		3. A key worker should be identified for liaison with the ***adult*** and/or their representative.	Relevant local authority	

		4. Consideration should also be given as to whether an outside expert should be consulted to help understand any specific aspects of the case.	TSAB Independent Chair/SAR Sub-Group Chair	
4	**Timescale for SAR Completion**	The TSAB will aim for completion of the SAR within 6 months of initiating it unless there are good reasons for a longer period being required. This could include for example, the need to delay the process due to legal proceedings or due to any relevant circumstances surrounding the adult. During any delay every effort should be made to capture learning from the case and apply to future practice. Following any criminal proceedings, the SAR should proceed without delay.	TSAB Independent Chair	Within 6 months of initiation

19. Safeguarding Adults Review Procedure Summary

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
1	**Initial SAR Governance Group Meeting**	1. The first SAR Governance Group meeting will review the: a) Scope of the SAR b) Methodology to be followed c) Timescale for completion of the SAR d) Arrangements for administrative support.	Independent Reviewer/SAR Governance Group	Within 28 days of the SAR being initiated Reasonably extended with the permission of the TSAB Independent Chair
		2. The scope and terms of reference should be proportionate to the nature of the case and should identify what appear to be the most important issues to address in identifying the learning from the case.	Independent Reviewer/SAR Governance Group	
		3. The Terms of Reference will: • Determine the timeframe during which events in the ***adult's*** life will be reviewed, taking into account the circumstances of the case • Outline the methodology to be used • Reflect Data Protection Act requirements and outline the arrangements for storage and transfer of personal information • Include a duty to report information to the Independent Chair if new information comes to light suggesting malpractice of individuals and/or organisations • Set out the arrangements for publication of the final report	Independent Reviewer/SAR Governance Group	
		4. The process for undertaking SARs* (methodology) 'should be determined locally according to the individual	Independent Reviewer/SAR Governance Group	

		circumstances. No one model will be applicable in all cases.' Indeed a hybrid model could be the most appropriate. The 'focus must be on what needs to happen to achieve understanding, remedial action and answers. *' *Care and Support Statutory Guidance, DH		
		5. Guidance on methodology from the Social Care Institute for Excellence can be found at http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/ *this guidance is not exhaustive and other methodologies can be used.		
		6. In the event of any other Statutory Review processes (Children's SCR, MAPPA, DHR etc.) or other significant processes (Police Investigation, Coroner's Inquest, HSE Investigation) taking place the chairs of the respective review processes should formally discuss and consider how the interfaces between these should be managed in order to maximise learning for individuals and organisations, and to avoid duplication for families and professionals.	Independent Reviewer	
		7. The SAR Governance Group should also: a) Consider if there are any specific considerations around, equality and diversity b) Consider how the review process should take account of previous lessons learned both nationally and regionally c) Consider if the Review Panel will need to obtain independent legal advice about any aspect of the review d) Consider how matters concerning family and friends, the public and media should be managed ***before, during and after*** the review e) Consider **how** to liaise with the ***adult*** and whether they require an advocate to support them f) Ensure that any learning identified at an early stage of the process is shared and acted upon.	Independent Reviewer/SAR Governance Group	
		8. The process will be supported by the Teeswide Safeguarding Adults Board (TSAB) Business Unit.	TSAB Business Manager	
2	**Process**	1. Some or all of the following actions/stages will be appropriate dependent on which methodology is being followed and will be determined by the Independent Reviewer and the SAR Governance Group:	Independent Reviewer/SAR Governance Group	

		a) Identify the evidence required from each agency/organisation including a chronology of events b) Produce/review of relevant evidence c) Analysis of evidence d) Produce Individual Management Reports (IMRs),outlining involvement and key issues e) Hold learning events to consider what happened and why, areas of good practice, areas for improvement and lessons learned f) Hold event to consider first draft of the overview report and action plan g) Formulate an Overview Report with analysis of key issues, lessons learned and recommendations h) Produce an action plan in response to the lessons learned		
		2. Liaison should take place with the ***adult,*** their advocate, relative or carers throughout the process.		
3	**Timescale**	1. The SAR Governance Group will aim for completion of the SAR within 6 months of its initiation, unless there are good reasons for a longer period being required. This could include the need to delay the process for legal proceedings or due to relevant circumstances surrounding the ***adult.*** During any delay every effort should be made to capture learning from the case and apply to future practice. Following any criminal proceedings, the SAR should proceed without delay.	Independent Reviewer/SAR Governance Group	
		2. The SAR Sub-Group Chair should report regularly on progress to the TSAB.	SAR Sub-Group Chair	Bi-monthly
4	**Reports**	1. All reports should be anonymised unless the family requests otherwise. Discussion will take place with the ***adult and/or their family*** regarding the use of pseudonyms within the report. The report should be 'written in plain and easy to understand language, provide a sound analysis of what happened and why; and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a reoccurrence*. ' * Care and Support Statutory Guidance, DH	Lead Reviewer	Within 6 months of the SAR being initiated Reasonably extended with the permission of the TSAB Independent Chair
		2. The Lead Reviewer should present the Final Report; Executive Summary and draft action plans to a SAR Governance Group meeting for agreement. The agreed documents should then be	Lead Reviewer	

		forwarded to the TSAB Independent Chair by the Business Manager.		
		3. The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the TSAB	Lead Reviewer TSAB Independent Chair/Board Members	Within 6 months of the SAR being initiated Reasonably extended with the permission of the TSAB Independent Chair
		4. A reason should be given for any decision where the TSAB decides not to implement a recommended action.	TSAB Independent Chair	
		5. Liaison should take place with the ***adult*** and/or their representative regarding the final report.	Lead Reviewer/Key Worker	
		6. The relevant Local Authority will ensure there are appropriate arrangements in place to support the ***adult and/or family members*** in preparation for, and following the publication of the report.	Local Authority/ independent Chair	
5	**Sharing the Learning**	1. The TSAB should agree the dissemination of learning, which will include providing feedback to staff and agencies involved in the case.	TSAB/Business Unit	Within 28 days of agreement of the final report
		2. The TSAB should arrange SAR briefings for a wider audience to share the lessons learned from the case.	TSAB/Business Unit	As above
6	**Publication of Reports**	1. All Safeguarding Adults Reviews conducted within the year will be referenced within the Teeswide Safeguarding Adults Board's Annual Report together with any actions that it has taken or intends to take. All reports will be anonymised. The Annual Report will also include the reason for any decision where the TSAB decides not to implement an action.	TSAB Independent Chair	
		2. The Teeswide Safeguarding Adults Board will also consider publishing Safeguarding Adults Reviews together with associated action plans on its website.	TSAB Independent Chair/Board Members	
7	**Monitoring**	1. Arrangements for the monitoring of actions plans should be put in place as follows: a) Individual agency action plans to be monitored by the agency concerned b) Overall monitoring to be undertaken by the SAR Sub-Group c) A report on the implementation of action plans across partnerships to be given to the TSAB at an agreed frequency d) Liaison to continue to take place with the ***adult*** and/or their representative as appropriate	TSAB Members SAR Sub-Group Chair SAR Sub-Group Chair/TSAB Members Key Worker	On-going On-going At an agreed frequency As appropriate

20. Annexes

SAR 01: Safeguarding Adults Review Notification Form

SAR 02: Safeguarding Adults Review - Initial Chronology

SAR 03: Safeguarding Adults Review Recommendation Summary

SAR 04: Safeguarding Adults Review: Information for Families - Leaflet

SAR DECISION SUPPORT GUIDANCE: WEB-LINK