





# Sussex Safeguarding Adults Review Protocol

With thanks to Surrey Safeguarding Adults Board, on whose work this Protocol is built.

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# **Contents**

1.	Introduction	3
2.	Statutory guidance	3
3.	Purpose of a SAR	4
4.	Criteria for a SAR	5
5.	SAR operating framework and governance	6
6.	Submitting a SAR referral	6
7.	Deciding to undertake a SAR	7
8.	Making Safeguarding Personal	8
9.	SAR methodology	9
10.	Timescales	9
11.	The SAR report	10
12.	Publication and media	10
13.	Implementation and evaluation	11
14.	Review	11
Appe	endix A: SAR governance and process	12
Appe	endix B: SAR referral form (Official Sensitive)	13
Appe	endix C: SAR referrals briefing note	19
Appe	endix D: SAR guide for families, friends, and carers	22
Appe	endix E: Summary of Involvement (SOI) and Individual Management Review (IMR)	24

#### 1. Introduction

- 1.1. The Care Act 2014 places a statutory duty on Safeguarding Adults Boards (SABs) to undertake Safeguarding Adults Reviews (SARs).
- 1.2. This protocol has been developed by the Brighton & Hove, East Sussex, and West Sussex SABs to support the effective identification of, and response to, SARs across Sussex, and to ensure that the SABs are discharging their statutory duty. The protocol is part of the Sussex Safeguarding Adults Policy and Procedures.
- 1.3. The protocol aims to ensure that there is a consistent approach to the process and practice in undertaking SARs across Sussex that follows both statutory guidance and local policies. The protocol will help in deciding when to refer a case for consideration as a SAR. It is important that professional and agency referrers consider the SAR Referrals Briefing Note at Appendix C, which details the circumstances in which a SAR referral should be made.

# 2. Statutory guidance

- 2.1. The statutory guidance can be found on the <u>Gov.UK</u> website. The guidance states the following:
- 2.2. 14.162 SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- 2.3. 14.163 SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example they 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. SABs have the discretion to conduct a SAR in any other situations involving an adult in its area with needs for care and support.
- 2.4. 14.164 The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

# 3. Purpose of a SAR

- 3.1. The purpose of a SAR is to determine what the relevant agencies involved in the case might have done differently that could have prevented harm or death. It is not to enquire into how a person died, nor is it to apportion blame. It is to learn from situations, and to ensure that learning is applied to future cases to prevent similar harm occurring again.
- 3.2. It is not the purpose of a SAR to hold any organisation to account or identify how a person died. Other processes exist for this, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as those regulated by the Care Quality Commission (CQC), the Nursing and Midwifery Council, Social Work England, and the General Medical Council.
- 3.3. A SAR will ordinarily be considered following the conclusion of statutory or mandatory enquiries or investigations (e.g., police criminal investigation, section 42 safeguarding enquiry, serious incident review or a Learning Disability Mortality Review (LeDeR) or NHS) and/or complaints processes. However, on occasion, there may be situations where enquiries or investigations have not been completed, but the circumstances of the case necessitate that a SAR should commence in parallel to the other investigatory process. Decisions as to the need for and the appropriateness of this will be made on a case-by-case basis.
- 3.4. The purpose of conducting a SAR is to:
  - Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
  - Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
  - Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
  - Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.
- 3.5. It is acknowledged that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these. Information about other investigatory proceedings can be found in section 2.4 of the Sussex Safeguarding Adults Policy and Procedures.

#### 4. Criteria for a SAR

- 4.1. A SAR should always be considered if:
  - an adult has died, and 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); or
  - an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether or not it knew because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and
  - there is concern that partner agencies could have worked more effectively to protect the adult.
- 4.2. A SAB may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support.
- 4.3. If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, a discretionary review may be undertaken. Please see section 6.
- 4.4. The SABs will only consider cases where the person who has died or come to harm is ordinarily resident within their local authority area, as per the Care Act. In practice this means that each of the SAR subgroups will consider cases where the person is resident within their area at the time of their death or serious incident.
- 4.5. Should a person placed by either the Integrated Care Board (ICB), or by one of the three local authorities, in another area be the subject of circumstances that would necessitate a SAR, then it would be for the SAB of that locality to oversee and carry out a SAR.
- 4.6. Should the person not be an ordinary resident within the relevant local authority area, but the investigation required has been carried out by a Sussex agency (e.g. Sussex Police, NHS Sussex, or one of the local authorities) because the safeguarding incident has occurred within Sussex, then the relevant SAB will consider where the person was or is ordinarily resident. It can then be considered how to proceed in line with Making Safeguarding Personal. This will include considerations around when it may be appropriate to contact the person, family, or carers, and who is best placed to do this.
- 4.7. Boards and organisations should co-operate across borders, and requests for the provision of information should be responded to as a priority <u>– see ADASS</u>
  Safeguarding Adults Policy Network Guidance.

# 5. SAR operating framework and governance

- 5.1. A SAB is the only body that can undertake a SAR. SARs are overseen by the SAB, which is responsible for ensuring that effective systems are in place for the completion of SARs including:
  - decision-making in respect of undertaking reviews,
  - formally accepting reports, and
  - agreeing sign-off of the report for publication.
- 5.2. Responsibility for the management of SARs is delegated to the SAR subgroups. The membership of these subgroups includes the statutory members of the SAB (the Local Authority, Police and NHS Sussex ICB), with specific Terms of Reference that are reviewed annually.
- 5.3. The SAR subgroups meet on a planned basis throughout the year to consider SAR referrals, decide on next steps, and to co-ordinate SARs in progress.
- 5.4. Staff directly involved in the care and support of individuals subject to a SAR should be notified of the decision to undertake a SAR, and there is an expectation that support will be provided to them by their agency. The process and their involvement should be fully explained.
- 5.5. Involved organisations will be provided with copies of reports for comments on factual accuracy prior to the final draft. Where a SAR Panel is established, depending on the methodology being used, it will be the role of the Panel to ensure the report is factually accurate and based on the evidence gathered during the process.
- 5.6. All involved agencies will be asked to participate in identifying solutions to any recommendations of the review to support improvements in practice.
- 5.7. There is a commitment by Brighton & Hove, East Sussex, and West Sussex SABs to consider the progression of SARs in consultation, where appropriate. This is in order to ensure proportionality and efficiency in undertaking thematic reviews across areas where similar themes have been identified or to establish if relevant learning already exists from another SAR.
- 5.8. See Appendix A for an overview of the SAR governance and process.

# 6. Submitting a SAR referral

6.1. Any member of the public, professional or agency can make a referral for a SAR, in any situation where the criteria are met.

- 6.2. Members of the public should discuss with a professional or agency involved who will support to consider if the SAR process could be appropriate. If it is considered appropriate, the professional or agency should complete and forward a referral to the relevant SAB. If there is no professional or agency involved, contact should be made with the relevant SAB Support team (as listed in 6.5 below) who will discuss and complete a referral form if appropriate.
- 6.3. Professionals and agencies should refer to the SAR Referrals Briefing Note for guidance on relevant considerations and to ensure all steps required are followed (see Appendix C).
- 6.4. Professionals and agencies should discuss making a referral with their senior manager or organisation's safeguarding lead prior to submitting the referral and consider contacting the SAB's Support Team to discuss. Referrals should be submitted using the referral form at Appendix B.
- 6.5. Referrals must be submitted to the relevant SAB:
  - Brighton & Hove SAB <u>SafeguardingReviews@brighton-hove.gov.uk</u>
  - East Sussex SAB <u>SafeguardingReviews@eastsussex.gov.uk</u>
  - West Sussex <u>safeguardingadultsboard@westsussex.gov.uk</u> Tel: 03302 227952
- 6.6. As the referral will contain confidential information, it should be sent by secure email or be password-protected, with the password emailed separately.

# 7. Deciding to undertake a SAR

- 7.1. When a SAR referral is received, the relevant SAB Support Team will triage the referral to consider whether all the necessary information has been provided. A member of the SAB Support Team may contact the referrer for a discussion of the referral or to request additional information. The Chair of the relevant SAR subgroup will be informed of the referral, and the referral will be scheduled for discussion at the next SAR subgroup meeting.
- 7.2. In line with Making Safeguarding Personal the SAR subgroup should consider the involvement of the person, family, or carers from the outset of the referral. Wherever possible the person, family or carers should be advised of the referral. However, it is recognised that this may not always be appropriate, for example if contact may pose a risk. These discussions and decisions made should be clearly recorded in the SAR subgroup minutes and on the SAR referral form.
- 7.3. Where SAR referrals are submitted inappropriately in place of a safeguarding concern, the referrer will be signposted to the safeguarding referral pathway and informed that the SAR referral will be considered for closure or non-progression at the next SAR subgroup meeting.

- 7.4. When SAR referrals are discussed at the SAR subgroup, there is the opportunity for referring agencies to attend the meeting to present their referral.
- 7.5. The Chair of the SAR subgroup is responsible for deciding on the recommended outcome of the referral, based on the proposals made by the SAR subgroup. If necessary, legal advice will be sought where appropriate, and on a case-by-case basis. The recommendations are then forwarded to the Independent Chair of the SAB for endorsement.
- 7.6. If the criteria for a statutory review is not met, as endorsed by the Independent Chair, the SAR referral will be closed. Ordinarily, there will be no further action for the SAB. However, if it is considered that an action may be needed by the SAB, this will be taken forward outside of the SAR Protocol.
- 7.7. In the absence of the Independent Chair, the endorsement of the SAR Chair's recommendation for the outcome of a SAR referral, will be based on the views of the three Statutory Partners.
- 7.8. If there is a difference of opinion on the recommended outcome between the SAR Chair and the SAB Independent Chair which cannot be resolved, then the Director of Adult Social Services (DASS) will be involved to agree a way forward and reach a decision.
- 7.9. The referrer will be informed of the SAR subgroup decision and where the person, family or carers have been informed, referrers will be requested to feedback to them.
- 7.10. If the decision is made to undertake a SAR, the SAB will make arrangements to notify partner agencies of the Board and the CQC (regulator of health and social care services) if registered services are involved.

# 8. Making Safeguarding Personal

- 8.1. It is important that consideration is given at an early stage to the most appropriate means of engaging with and involving the person, their family and/or carers within the SAR process, where this is appropriate. If appropriate, contact will be made with all involved family members in the first instance to understand their desired level of involvement. This will be followed with written confirmation detailing with whom, and how frequently, ongoing contact will be maintained.
- 8.2. The person(s) will be notified that the review will look at records and notes held by public bodies, including adult social care and health providers. Consent will be requested but is not required for a SAR to go ahead. Those involved can be provided with a copy of the 'SAR Guide for families, friends, and carers' (see Appendix D).

8.3. Where appropriate, the SAB will make arrangements for the person and/or their family, or carers to participate in the SAR. Meetings may take place during the review with the SAR referrer to gain views and feedback from the person and/or their family or carers. The person and/or their family and carers should be kept updated at key stages of the review and notified of the publication of the report.

# 9. SAR methodology

- 9.1. The Care and Support Statutory Guidance states that SABs must identify the most appropriate review that will promote effective learning and encourage action to be taken that will prevent similar incidents happening again.
- 9.2. SARs can be conducted in a variety of ways and no one model will be applicable for all cases. The SAR subgroup will endorse the approach best suited and proportionate to the circumstances for each individual case. Models include:
  - Traditional SAR approach (Individual Management Reviews may be used as part of this methodology to request individual and organisational analysis from agencies involved)
  - Thematic Review
  - Systems Analysis
  - Learning Together
  - Significant Incident Learning Process
  - Significant Event Analysis
  - Appreciative Enquiry
- 9.3. The Care and Support statutory guidance advises that whatever methodology is adopted the following elements should feature:
  - SAR subgroup overseeing process
  - Terms of Reference
  - Involvement of relevant professionals, in terms of providing reports, attending SAR Panel meetings, learning or practitioner events
  - Agreed engagement or involvement with the person and/or their family
  - Final report with recommendations or questions for the Board to consider
- 9.4. The decision on the methodology must also take into consideration the cost, resources and length of time required to conduct the review.

#### 10. Timescales

- 10.1. SARs must be completed in a timely manner.
- 10.2. Once the decision to undertake a SAR has been made, it is good practice for it to be completed within nine months.

10.3. It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues which emerge from the review and need to be considered without delay should be brought to the attention of the SAB.

# 11. The SAR report

- 11.1. The SAR report should:
  - provide a sound analysis of what happened
  - contain findings or recommendations of practice value to organisations and professionals, and
  - be written concisely and in plain English.
- 11.2. Where possible, the report and its findings will be shared with the person, and/or their family and carers.
- 11.3. Where possible and practicable, the person(s) and/or their family or carers will be consulted, to agree how the person(s) in the review will be referred to.
- 11.4. The final report will be signed-off by the SAB.

# 12. Publication and media

- 12.1. The SAR Panel Chair, in consultation with the SAB Independent Chair, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the person(s), their family or carers (where possible).
- 12.2. Any media and communication issues will usually be co-ordinated by the relevant council's Communications Team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.
- 12.3. All SAR reports will be considered for publication on the website of the relevant SAB. In some cases, an executive summary of the SAR is published. In the case of publication, the Independent Chair of the SAB will release a statement where appropriate.
- 12.4. It may be necessary to delay the publishing of reports in some circumstances, for example, pending the conclusion of a criminal investigation. However, individual agencies can progress with implementing the learning from the review.

# 13. Implementation and evaluation

- 13.1. The real value of the completion of a SAR is to ensure that the relevant lessons have been learnt and that professional multi-agency safeguarding is improved, in order to prevent the issues in question happening again.
- 13.2. The SAR subgroup will consider the recommendations from the report and agree an action plan (if required).
- 13.3. The SAR subgroup will be responsible for ensuring the implementation of the action plan, monitoring the progress made, and making links with relevant subgroups of the Board to take forward assurance and learning.
- 13.4. Following the completion of a SAR, a learning briefing highlighting the key themes will be produced so that agencies can consider the learning required and what actions need to be taken to embed the learning and improve practice.
- 13.5. In line with Making Safeguarding Personal, and as appropriate, feedback will be sought from the person, their family, or carers to share their experience of the SAR process in order to develop and improve practice in this area. Each SAB will use their own feedback form for this stage of the process.

#### 14. Review

14.1. There will be a formal annual review of this protocol to take account of developments and new legislative requirements.

# Appendix A: SAR governance and process

#### **Board Support Team**

Triages referral form and notifies SAR subgroup Chair/SAB Independent Chair

#### **SAR** subgroup

Consideration and recommendation of whether to progress to a SAR or other response such as a learning review

Decision confirmed with SAR subgroup Chair/SAB Independent Chair

#### **Board Support Team**

Feedback to referrer

Referrer to feedback to person/family as appropriate

Contract reviewer/decide on methodology/draw up Terms of Reference (ToR)

#### **SAR Panel**

Agreement of the Terms of Reference and oversight of the SAR process

Consideration of the involvement of adult/family in the SAR

#### **SAR** undertaken

Involvement of person/family throughout as appropriate

SAR Panel/SAR subgroup oversight and quality assurance

#### **Safeguarding Adults Board**

Presentation of report to the SAB for sign-off



#### **Action Plan/Publication**

Develop Action Plan and publish report, with SAB response where appropriate

# **Appendix B: SAR referral form (Official Sensitive)**

#### Section 1: Referrer guidance

Before submitting your referral, please consider the information below in conjunction with the Safeguarding Adults Review (SAR) Referrals Briefing Note.

All SAR referrals will be considered by the SAR subgroup in accordance with the Sussex SAR Protocol and the <u>Sussex Safeguarding Adults Policy and Procedures</u>.

The purpose of a SAR is not to apportion blame. It is to identify recommendations to promote effective learning and improvement. This is in order to minimise the risk of future deaths or serious harm occurring again. It is important that any information shared with families, or those personally involved with the adult, about your referral makes this explicitly clear.

On the receipt of a SAR referral, if the criteria for a SAR is met, the relevant Safeguarding Adults Board (SAB) will consider what type of 'review' process could promote effective **multi-agency learning** and improvement action to minimise risk of future deaths or serious harm occurring to **adults with care and support needs**.

In completing your referral, please provide as much information as possible and ensure the following has been considered:

- 1. Contact the relevant SAB to discuss whether a potential referral is appropriate.
- 2. In line with the SAR criteria, check the following:
  - If the person is alive, has there been **serious abuse/neglect**?
  - Did or does the person have eligible care and support needs within the meaning of the Care Act 2014?
  - Has there been a **concluded enquiry/investigation** by an agency (e.g. Adult Social Care, Police, Health)?
  - Is there an indication for **multi-agency** learning?
- 3. Has the person or family been informed that a SAR referral is being made and that this is for multi-agency learning rather than any additional investigation to find accountability? If contact with the person/family is not deemed to be appropriate, please outline the reasons why.

#### **Section 2: Referral Information**

Referrers should complete Section 2 only, before submitting the entire form to the relevant SAB:

- Brighton & Hove SAB <u>SafeguardingReviews@brighton-hove.gov.uk</u>
- East Sussex SAB <u>SafeguardingReviews@eastsussex.gov.uk</u>
- West Sussex SAB safeguardingadultsboard@westsussex.gov.uk

As the referrals will contain confidential information, they should be sent by secure email or be password-protected, with the password emailed separately.

#### Your information

Your name	
Your agency	
Your position	
Your email address	
Your contact address	
Your contact number	
If you are referring from an agency,	
please confirm that this referral has	
had senior oversight, and please	
provide their name and role.	

#### Details of the person being referred

Their name	
Their date of birth	
Their next of kin	
Date of death, incident, or issues	
Is the person deceased or alive?	
If the person is deceased, is the	
cause of death known?	
Do you know if the death has been	
reported to the coroner?	
Has the person or family member	
been informed of the purpose of a	
SAR, and that a referral is being	
made?	
Where it is felt not appropriate to	
inform the person or family, please	
explain why.	

#### Agency involvement

Please provide the details of any agency working with the person, if known. If you run out of space to record agency involvement, please either add additional rows into this table, or provide the information on a separate sheet.

Agency	Key contact name	Contact details	Agency informed of SAR referral?

Agency	Key contact name	Contact details	Agency informed of SAR referral?

#### Reason for referral

Please explain how the criteria for a SAR has been met.

Describe the safeguarding incident preceding the person dying or the incident resulting in serious abuse/neglect
Document enquiries, investigations, or complaints that have taken place, by who, and what the outcome of these have been – please send copies if possible
What are/were the person's care and support needs?
Explain why you think the SAR eligibility criteria has been met and where there is a case for multi-agency learning
Any other information you want to share

#### Submission

Completed by	
Signed	
Date	

Please provide any supplementary documentation which could support your referral, such as:

- Section 42 report
- Serious Incident Review
- Root Causes Analysis
- Provider internal investigation report
- Domestic Homicide Review
- Local Safeguarding Children Partnership Serious Case Review
- Learning Disabilities Mortality Review (LeDeR)
- Chronology

#### OFFICE USE ONLY FROM HERE ONWARDS

# **Section 3: Triage by the Board Support Team**

This section should be completed by the Board Support Team, and used to evidence contact made with, and information received from, agencies. This triage information should include the view of agencies with regards to whether a SAR would be appropriate.

### Triage information from the referrer

Key contact

Date referral received	
Date of contact made with the	
referrer	
Summary of discussion with the	
referrer	
Triage information from supporting	agencies
•	
Agency	
Key contact	
Contact information	
Date of contact made with the	
agency	
Summary of discussion with the	
agency	
Agency view of referral	
Agency	
Key contact	
Contact information	
Date of contact made with the	
agency	
Summary of discussion with the	
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Agency view of referral	
A	
Agency	
Key contact Contact information	
Date of contact made with the	
agency	
Summary of discussion with the	
agency Agency view of referral	
Agency view of referral	L
Agency	

Contact information		
Date of contact made with the		
agency		
Summary of discussion with the		
agency		
Agency view of referral		
Agency view of referral		
Agency		
Key contact		
Contact information		
Date of contact made with the		
agency		
Summary of discussion with the		
agency		
Agency view of referral		
Links or similarities with local/nation	nal reviews	
Please note any local or national		
reviews containing similar incident		
or themes		
Triage decision		
Does it appear that the criteria for a		
SAR have been met?		
Summary for SAR Subgroup		
Consideration		
Name and role		
Date		
Section 4: SAR subgroup consideration  This section should be completed once the SAR Panel has considered the referral and the		
triage information.		
Subgroup decision		
Date of consideration		
Recommendation and rationale for		
decision (this will usually be taken		
from the minutes of the SAR		
subgroup meeting)		
Next steps, including:		
feedback to the referrer		
accessing a SAR reviewer		
<ul> <li>proposed methodology</li> </ul>		
1	1	

•	initiation of an alternative review
	type, such as a single agency
	review
•	more information required, such
	as IMRs or SOIs

# Section 5: Independent Chair Sign-Off

This section should be completed once the Independent Chair has considered the view of the SAR subgroup.

Date of consideration	
Comments from Independent Chair	
Chair's name	
Chair's signature	

# Appendix C: SAR referrals briefing note

This briefing note has been produced to support those submitting SAR referrals to ensure the SAR criteria are fully considered and all relevant information provided.

#### 1. The Care Act 2014

- 1.1. Safeguarding Adults Boards (SABs) have a statutory responsibility to consider arranging a Safeguarding Adults Review (SAR) when there is concern that partner agencies could have worked together more effectively to protect an adult with care and support needs if they:
  - die as a result of abuse or neglect, whether known or suspected;
  - experience serious harm;
  - take their own life.
- 1.2. The purpose of a SAR is to promote agencies' learning and improve practice with the intention of reducing the risk of reoccurrence of the safeguarding incident.
- 1.3. The objectives of SAR include establishing:
  - lessons that can be learnt from how professionals and their agencies work together;
  - how effective the safeguarding procedures are;
  - learning and good practice issues;
  - how to improve local inter-agency practice;
  - service improvement or development needs for agencies.
- 1.4. It is not the purpose of a SAR to:
  - be a primary investigation process;
  - re-investigate a safeguarding incident;
  - apportion blame;
  - substitute for a complaints process.

#### 2. Considering making a SAR referral

- 2.1. When thinking about making a referral please ensure the following points are considered alongside the Care Act criteria:
  - If the person is alive, has there been serious abuse or neglect?
  - Did or does the person have care and support needs?
  - Has there been an enquiry or investigation by an agency (e.g. Adult Social Care, Police, Health) which has concluded?

- Is there an indication for multi-agency learning?
- 2.2. Discuss the appropriateness of a referral with your supervisor, manager, or safeguarding lead:
  - Consider the criteria above and the information in this briefing paper.
  - Look at the referral form to see if you are able to evidence in all sections how the criteria are likely to be met.
- 2.3. Consider calling the SAB Support Team. Following steps (1) and (2) contact the SAB Support Team to discuss and consider whether a referral is appropriate (i.e. that the criteria are likely to be met).

#### 3. Making a SAR referral

- 3.1. In the context of Making Safeguarding Personal, the person and/or their family or carers should be informed that a SAR referral is being made.
- 3.2. If there are reasons why it is felt it is not appropriate to inform the person and/or their family or carers, the rationale for this should be clearly recorded in the SAR referral.
- 3.3. Where the person and/or their family or carers are informed that a SAR referral is being made, it is important to provide clear and accurate information so as not to elevate hopes and/or convey inappropriate expectations of a SAR. It is therefore necessary for you to ensure that the person and their family or carers are clear:
  - Why you are making the referral (e.g. since there may be an indication for multiagency learning).
  - It is not another investigation into the incident.
  - It is not a complaints process.
  - It is not a route to apportioning blame.
  - You are not making promises that this process is the right step; rather, you are
    asking via the referral for consideration of whether a SAR may be appropriate
    or not. So, it is not a foregone conclusion that a review will be appropriate or will
    happen
  - You will feedback on the outcome of your referral.
- 3.4. Complete the SAR referral form:
  - Complete as fully and with as much detail as possible;
  - Complete a separate SAR referral form for each individual being referred.
  - Be clear about what investigation:
    - has already concluded (e.g. Serious Incident, Root Cause Analysis, s42 Safeguarding Enquiry, Criminal investigation);
    - o by which agency (e.g. police/Health, Social Care); and
    - what the outcome was.

• Submit the form via email to the relevant Safeguarding Adults Board.

# 3.5. Following your referral:

- The SAR subgroup meets monthly and will consider your referral against the criteria.
- The subgroup's decision will be fed back to you.
- You will then need to feedback to the adult and/or their family or carers.

# Appendix D: SAR guide for families, friends, and carers

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#### What is the Safeguarding Adults Board?

The Brighton and Hove, East Sussex, and West Sussex Safeguarding Adults Boards (SABs) works with organisations across Sussex to ensure that they have safeguarding policies and procedures in place and work together in the best way possible to protect adults with care and support needs.

#### What is a Safeguarding Adult Review (SAR)?

Safeguarding Adults Boards have a duty to carry out a SAR when an adult dies as a result of abuse or neglect. This is whether abuse or neglect is known or suspected, and there is information to suggest that partner agencies could learn lessons and improve the way they work together to support adults at risk in the future. A SAR may also take place when an adult has not died but it is known or suspected that they have suffered serious abuse, harm, or neglect. The full criteria of a SAR is set out in the Care Act 2014.

The purpose of a SAR is not to apportion blame. It is to identify recommendations to promote effective learning and improvement. This is in order to minimise the risk of future deaths or serious harm occurring again.

Each of the Sussex SABs has a SAR subgroup which meets monthly to discuss and make decisions regarding new referrals, oversees current reviews, and ensures learning from reviews is used to make improvements to services. The groups also monitor reviews from other Safeguarding Adults Boards to ensure any relevant learning is considered.

#### How long will the review process take?

Our aim is for the review process to be completed in around nine months, unless there are good reasons for a longer period being required.

#### Who will carry out the review?

The review will be supported by agencies who have worked with the adult, and the SAB will appoint an Independent Reviewer with the appropriate skills and experience to lead on the review. The Independent Reviewer will make contact with the key family members, carers, professionals, and organisations who were involved with the adult to invite them to contribute to the review.

#### How will I be involved?

It is very important to the Sussex SABs that our reviews include family members or important people in the adult's life. We will ask you to share your experiences so that we can

understand fully what happened, identify what lessons should be learned and what has worked well so that your contributions can be used to develop recommendations.

The relevant SAB will make contact with you early in the process to discuss the review and agree how much you wish to be involved. If you decide you would like to contribute to the review, you will be asked to share your understanding of what happened and why.

You can give your thoughts and views in different ways. Some examples include having a face-to-face meeting with the Independent Reviewer, a telephone conversation, or providing feedback in writing. It is your decision as to how much involvement you would like to have in the review. As there is a legal duty to undertake a SAR, the review will still go ahead if you decide not to contribute.

We understand that this might be a difficult and upsetting time for you and we will try to support you as much as possible if you decide to contribute.

#### Who will see the report?

The report and recommendations will be presented to SAB members for sign-off and will also be shared with any family members, friends, and carers who have contributed to the review.

If possible, the report will be published on the Board's website but sometimes a decision is made to not publish depending on the circumstances of the case. Published reports can be anonymised, or if it is the family's wish, can include the adult's name.

#### What will happen next?

The SAB will write an action plan based on the findings of the review to make sure any recommended improvements are made to services. The SAR subgroup is responsible for making sure that agencies report on their progress and provide evidence for how practice has changed and improved.

#### Further information

At any point in the SAR process, please feel free to contact the SAB Support Team:

- Brighton & Hove SAB SafeguardingReviews@brighton-hove.gov.uk
- East Sussex SAB <u>SafeguardingReviews@eastsussex.gov.uk</u>
- West Sussex SAB <u>safeguardingadultsboard@westsussex.gov.uk</u>

# **Appendix E: Summary of Involvement (SOI) and Individual Management Review (IMR) questions**

The information requested on this form is necessary to understand the multi-agency involvement with the individual.

About the individual				
Name				
Date of birth				
Date of death (if applicable)				
Address				
Details of review				
(Note for SAB worker provide details of review with reason as appropriate)				
Information needed for the following time period				
About you				
Name				
Job title				
Name of your agency				
Phone number				
Email address				
Date and details of other reviews completed by your agency for this individual (e.g. Section 42 enquiry, SIRs, LeDeR, RCA)				
Other agencies that you are aware of who have worked with this Individual (e.g. voluntary sector)				
Chronology				

If your agency has already completed a chronology that can be shared, you do not need to complete the chronology on this form.

**If you do NOT have a Chronology** – please use the table below to provide a **brief** factual **summary** of your agency's involvement with the individual.

Please include all contact with the individual, contacts could be in relation to, for example:

- Assessments/reviews
- Phone contact
- Appointments
- Contacts with other agencies/friends/family (with contact info where possible)
- Changes in level of need/engagement
- Referrals to other agencies, and how these were received

Additional sections of the table can be added by clicking on 'Layout' and then 'Insert Below'.

Date of contact	Details of your agency involvement	Outcome of contact		
Has your agency considered its involvement with this individual and has any action been				
taken as a	a result?			
Declaration	on:			
I confirm that this is an accurate Summary of Involvement in line with Sussex SAR protocol.				
I have ensured that, if required, all information on this form has been shared with Senior				

managers within my agency prior to returning to the Safeguarding Adults Board.

Signed:
Role and agency:
Date:
Please complete and return to (Delete as appropriate)
Brighton & Hove SAB – <u>SafeguardingReviews@brighton-hove.gov.uk</u>
East Sussex SAB – <u>SafeguardingReviews@eastsussex.gov.uk</u>
West Sussex SAB – <u>safeguardingadultsboard@westsussex.gov.uk</u>

#### Additional Individual Management Review (IMR) Questions

#### Please only complete this section if requested to do so by the Safeguarding Adults Board.

The aim of the IMR is to look openly and critically at individual and organisational practice. Your agency is expected to analyse its involvement, consider the events that occurred, the decisions made, and any actions taken or not. Where these indicate that practice, management and/or systems could be improved, please state actions that have been taken to make these improvements.

If any sections do not apply to your agency, then identify that this is the case in the appropriate box.

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

**Policy and procedure:** Did your agency have policies and procedures for safeguarding adults? When were these policies last reviewed?

**Individual's voice:** Were outcomes agreed with the individual(s) and wishes the focus of your agency's involvement? If so, explain how, if not how have measures been implemented to ensure this since the concern.

Did your agency ensure that the individual(s) were satisfied with the outcome of your involvement? If so, how if not if not how have measures been implemented to ensure this since the concern?

**Staff knowledge and awareness:** Were all staff sensitive to the needs of the individual(s) in their work; knowledgeable about potential indicators of abuse or neglect; and aware of how to share and raise concerns?

**Care and support planning:** Was there a clear care plan for the individual? Was this care plan adhered to?

**Professional standards:** Please note whether all staff actions and practices adhered to the standards of care that they were required to provide, and was this in relation to organisational policy and expectations and/or in accordance with formal professional standards?

**Services provided:** Were all appropriate services offered and/or provided or were there gaps – if so please explain and measures have been taken to address this? Were relevant enquiries made?

**Assessment and decision making:** What were the key relevant points and opportunities for assessment and decision making in relation to the individual(s)? Is there evidence that assessments and decisions have been reached in an informed and professional way?

**Specific safeguarding arrangements:** Where relevant, were appropriate safeguarding plans in place and safeguarding adults reviewing processes complied with?

**Capacity:** Was a Mental Capacity Act assessment of the individual(s) completed? Was this information recorded?

**Senior oversight and scrutiny:** What was the senior management oversight for the individual(s) Did your staff escalate any issues of concern, raise matters of concern with other professionals or seek guidance where necessary?

**Process and actions:** Are you satisfied that all the care provided to the individual was satisfactory? After the person had died (if relevant), are you satisfied that all appropriate actions, process, and investigations were undertaken to fully determine if the care of the individual had contributed to their death?

**Equality and cultural sensitivity:** Was the practice of all people involved in the care of the individual(s) from your agency sensitive to the racial, cultural, linguistic, and religious identity of the individual(s)?

**Additional factors:** Are there are any features of this case, or issues surrounding the death or injury of the individual(s), that you consider require further comment in respect of your agency's involvement.

#### **Learning and Recommendations**

This following section is to consider any learning from your agency's perspective or wider learning that the Safeguarding Adults Review (SAR) subgroup could consider?

Are there lessons from this case for the way in which your agency works to appropriately support individuals and/or safeguard them?

Is there any good practice to highlight?

Is there learning and improvement required to your system pathways for individuals?

Are there implications for the management of staff within your agency and/or supervision of staff who work for your agency?
Are there implications for working in partnership with other organisations?
Are there implications for service provision within your organisation?
Are there any training needs identified?
Are there any other issues, implications, or remedial actions for your agency?

Please provide an overall conclusion of your review.

Based on your review and conclusions, please set out the recommendations that you propose for your agency. These should be specific, achievable, and measurable. A view on how these could be achieved should be included.

Recommendations fall into two categories:

- **Review** consideration of what practice, systems and processes need to be reviewed as a result of the concern.
- New actions that need to be introduced and implemented as a result of your review.

Recommendations should also be identified as either multi-agency and/or single agency.

If you require further space for recommendations additional boxes can be copied and pasted.

Recommendation 1	
Review/New	
Agency	
Lead professional	
Action (required or taken)	
Timescale	
Barrier to implementation	
Outcome of action	
Please provide a summary of the impact of	
the recommendation, how the agency has	
learnt lessons and identify source of	
evidence to demonstrate learning.	
Progress	
Please state whether action arising from the	
recommendation is 'completed', 'in	
progress', or 'not yet achieved'.	

Recommendation 2	
Review/New	
Agency	
Lead professional	
Action (required or taken)	
Timescale	
Barrier to implementation	
Outcome of action	
Please provide a summary of the impact of	
the recommendation, how the agency has	
learnt lessons and identify source of	
evidence to demonstrate learning.	
Progress	
Please state whether action arising from the	
recommendation is 'completed', 'in	
progress', or 'not yet achieved'.	
Recommendation 3	
Agency	
Lead professional	
Action (required or taken) Timescale	
Barrier to implementation	
Outcome of action	
Please provide a summary of the impact of	
the recommendation, how the agency has	
learnt lessons and identify source of	
evidence to demonstrate learning.	
Progress	
Please state whether action arising from the	
recommendation is 'completed', 'in	
progress', or 'not yet achieved'.	
Recommendation 4	
Agency	
Lead professional	
Action (required or taken)	
Timescale	
Barrier to implementation	
Outcome of action	
Please provide a summary of the impact of	
the recommendation, how the agency has	
learnt lessons and identify source of	
evidence to demonstrate learning.	
Progress  Please state whether action arising from the	
Please state whether action arising from the recommendation is 'completed', 'in	
progress', or 'not yet achieved'.	
progress, or not yet acriieved.	

I confirm that this is an accurate Individual Management Review in line with the Sussex SAR protocol. I have ensured that, if required, all information on this form has been shared with Senior managers within my agency prior to returning to the Safeguarding Adults Board.		
Signed:		
Role and Agency:		
Date:		
Counter signature by Senior Manager/Safeguarding Adults Board Member:		
Date:		
Please complete and return to (Delete as appropriate)		
Brighton & Hove SAB – <u>SafeguardingReviews@brighton-hove.gov.uk</u>		
East Sussex SAB – <u>SafeguardingReviews@eastsussex.gov.uk</u>		
West Sussex SAB – <u>safeguardingadultsboard@westsussex.gov.uk</u>		
no later than <insert date="">.</insert>		