Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

SSASPB

Safeguarding Adult Reviews (SAR) Protocol and Procedure

(incorporating the West Midlands Regional SAR Policy)

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1. Introduction

The Care Act 2014 requires Safeguarding Adult Boards (SABs) to arrange Safeguarding Adults Reviews (SARs), mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

This Protocol reflects and supports the West Midlands Regional Safeguarding Adult Review Policy and includes elements within it to be used as local procedures in Stoke-on-Trent and Staffordshire (hyperlink).

Social Care Institute for Excellence (SCIE) is producing SAR Quality Markers which intend to standardise how learning from SARs is captured. This is intended to enable all SABs to learn from each other's reviews which will support proactive and preventative activity nationally.

The Quality Markers (QMs) process is yet to be implemented, but once done the SAR Policy will be updated to include appropriate text and references.

A Safeguarding Adult Review is a multi-agency process that considers what lessons can be learnt. This includes highlighting areas of best practice, thereby enabling practice improvement through the development of briefing notes which are shared with partners and published on the dedicated SSASPB

website, messages to Board partners and presentations all of which enable the partnership to improve services and prevent abuse and neglect in the future.

Staffordshire and Stoke-on Trent Adult Safeguarding Partnership Board (SSASPB) acknowledges the value of the work of the Safeguarding Adult Review (SAR) Sub-Group as an essential element in supporting the Board in its key objective of preventing abuse and neglect of adults at risk.

The SAR Sub-Group of the SSASPB is responsible for recommending the commissioning of Safeguarding Adult Reviews (SARs) in line with the Care Act 2014 Guidance (Chapter 14)[1], managing the process and assuring the SSASPB those recommendations and actions have been addressed by the partnership and individual agencies. This document sets out the criteria for conducting a SAR and outlines options for the methodology used for these learning reviews. The guidance and templates highlight roles and responsibilities within the process and clarify governance arrangements.

For the purposes of this Protocol an "adult" refers to someone aged 18 years and over that:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- 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.

2. Purpose of a Safeguarding Adult Review

The overriding purpose of a Safeguarding Adult Review is to learn lessons and improve practice and inter-agency working.

The Care Act 2014 guidance outlines that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that may have prevented serious 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.

'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' (March 2013) provides some clarity in relation to the purpose of the Safeguarding Adult review process:

"The overriding reasons for holding a review must be to learn from past experience, improve future practice and multi-agency working. ***It is not the role of Safeguarding Adult Reviews to apportion blame*** *- that is for the courts or other arenas. Boards should have a protocol for how and when to commission a Safeguarding Adult Review and, equally importantly, stating how they will implement and monitor the recommendations."*

The purpose of holding a Safeguarding Adult Review is to:

- establish the facts

- establish what lessons can be learnt from the circumstances of the case about the way in which local professionals and agencies (or any other person involved in the care of the adult) work together to safeguard and promote the welfare of adults
- review the effectiveness of procedures (both multi-agency and those of individual organisations)
- inform and improve local inter-agency practice and commissioning arrangements
- improve practice by acting on learning and developing best practice
- highlight good practice identified in the course of the review
- provide an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

It is not the function of a Safeguarding Adult Review to hold any individual or organisation to account – other processes exist for that including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission (CQC), the Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC), the General Medical Council (GMC) and Coroner's Court.

A Safeguarding Adult Review is NOT:

- to re-investigate or apportion blame
- to address professional negligence. Should the review identify necessary disciplinary action this should be addressed through agencies' own disciplinary procedures and agency representatives therefore need to be cognisant of their organisation's disciplinary procedures
- an enquiry into how an adult at risk has died or who is culpable. These are matters for the Coroner's Court, Criminal Courts or employment procedures to determine as appropriate
- a Judicial Inquiry: there is no oral evidence or cross-examination of that evidence.

It is acknowledged that agencies will have their own internal/statutory review procedures to investigate serious incidents; e.g. an NHS Serious Incident (SI) investigation, and their own mechanisms for reflective practice and to raise standards. This protocol is not intended to duplicate or replace these. Where other procedures are ongoing the commencement of the Safeguarding Adult Review process will be considered on a case by case basis and will not necessarily be delayed until other procedures have been finalised; please refer to SAR 4b – Parallel Process guidance.

3. Criteria

In April 2015 the requirement to undertake SARs became statutory through the Care Act 2014, Section 44 (2) which states:

(1) A Safeguarding Adult Board (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) An 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

4. General Principles

i. Adult Safeguarding Principles

The Department of Health sets out the Government's statement of principles for developing and assessing the effectiveness of their local adult safeguarding arrangements and in broad terms, the desired outcomes for adult safeguarding, for both individuals and agencies. These principles will be used by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and partner agencies with safeguarding responsibilities to benchmark their adult safeguarding arrangements:

Principal	Description	Outcome for Adult at Risk
Empowerment	Presumption of person led 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	Proportionate and least intrusive response appropriate to the risk presented.	*"I am sure that the professionals will work for my best interests, as I see them and will only get involved as much as needed."* *"I understand the role of everyone in my life."*
Protection	Support and representation for those in greatest need.	*"I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able"*
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 to get the best result for me."*
Accountability	Accountability and transparency in delivering safeguarding.	*"I understand the role of everyone in my life."*

By adopting the above principles, the SSASPB will be able to demonstrate its commitment to Making Safeguarding Personal (MSP) and the SAR review panel will ensure that the review conclusions reflect MSP wherever possible. MSP guidance can be found here.

ii. Partnership approach to SARs

The Care Act Guidance 2014 outlines that it is vital, if individuals and organisations are able to learn lessons from the past, that SARs are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response could be defensive and their participation may be guarded and partial. The SAR Sub-Group have agreed the following principles as a guide when conducting SARs:

Positive reflection:	The intention of SARs is to learn and improve services, not to blame any individual or specific agency. There should be a culture of continuous learning and improvement across organisations that work together to safeguard and promote the wellbeing and empowerment of adults. Reviews will identify opportunities to draw on what works and highlight positive and innovative practice as well as that which could have been different.
Timeliness:	Agencies must respond to a decision to undertake a SAR with appropriate urgency. Priority must be given to ensuring that the timescales set down in these procedures are adhered to and reviews are undertaken in a timely manner
Impartiality:	The SSASPB is independent of any of its partner agencies. The review will be conducted fairly and impartially and led by individuals who are independent of the case and of the organisations whose actions are being reviewed. It is recommended that those who have had direct involvement with the adult should not therefore be responsible for drafting the reports.
Thoroughness:	The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined. It is essential that the review process is robust and committed to exploring each of the terms of reference in detail and those professionals who may have relevant information are invited to contribute their perspectives. In some cases, it may be helpful to communicate with the person who caused the abuse or neglect.

Openness and accountability:	The individual (where able) and their families should be invited to contribute to reviews and there should be early discussions to agree how they will be involved and their expectations managed appropriately and sensitively. The adult or family must be informed of any decision not to have early engagement with them together with the reasons for the delay. Review outcomes will be shared appropriately with the family and others affected by the SAR. The process will be conducted in accordance with the SSASPB and member agencies' governance arrangements.
Confidentiality:	All information gathered throughout the process will be treated as confidential and will only be shared or disclosed in line with the relevant information sharing and legislative guidance.
Co-operation	The SSASPB provides a framework to ensure close collaboration between all organisations and agencies involved in SARs.
Resolution:	At the conclusion of the SAR an Action Plan will be completed setting out actions that each individual agency must take to ensure that lessons are learnt and influence service delivery. Progress towards the action plans will be monitored and reported upon to the SSASPB through the SAR Sub-Group.

All members of a SAB and/or their staff are expected to have a culture of openness, transparency and candour within their day to day work and with the SAB including any SARs undertaken.

Definitions:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice - as a member of the SSASPB it is expected that all agencies will be open and transparent with the SAB when serious incidents occur in relation to the care and treatment provided to people who use their services and also ensure that their staff understand their responsibility to report all incident that meet the criteria for a SAR. The SSASPB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying their own and multi-agency learning.

5. Cross Boundary SARs

It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is not in the SABs area. If that is the case, a SAR should be carried out by the Board that is responsible for the location where the serious incident took place. Early consideration should be given inviting a representative from the SAB of the funding area to participate in the SAR. The SAB representative from the funding area has the responsibility of sharing all learning and ensuring and recommendations/ actions for their area are implemented within agreed timescales.

Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

6. SARS and Childhood Experience of Abuse

It is acknowledged that there will be cases where adults have moved from Children's to Adult Services and their predominant experience of abuse happened before the age of eighteen. Early consideration should be given to identifying the most appropriate route for responding to the concerns raised for example, historic child abuse may be more appropriately dealt with by the Police or reviewed by Local Children's Safeguarding Partnerships (LSCP).

The SAR will focus upon a person's experience of abuse as an adult.

7. Adult/Family Involvement and Independent Advocacy

Care Act 2014 statutory guidance indicates that adults, their families and/or representatives should be invited and supported to contribute to SARs. This will enable an inclusive approach and ensure that their wishes, feelings and needs are fully considered. The SSASPB Manager will arrange for contact to be made with the adult, their family and/or representative to inform them that a SAR referral has been received and accepted for scope and to establish:

(a) How they would like to be involved, e.g. telephone conversation, written communication, face to face conversation

(b) Any support or adjustments they would need to facilitate their involvement

(c) Their initial views, wishes, concerns and any answers/outcomes they would like to achieve from the SAR

The SSASPB has developed a leaflet that supports members of the public to understand the purpose of a SAR process which may be shared with family members and friends – see SAR 6.

Local Authorities must arrange an independent advocate for adults who are subject to a SAR if the following two conditions are met:

- that if an independent advocate were not provided the person would have substantial difficulty in being fully involved in the process

and

- there is no appropriate individual available to support and represent the person's wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer

It is for the local authority to form a judgement on a case by case basis about whether the adult has 'substantial difficulty' in being involved in the SAR process.

The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the local authority and other organisations as required for the SAR, to help them to understand and take part in the review and to express their views wishes or feelings.

8. Links with other reviews (parallel processes)

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both Child Safeguarding Practice Review (SPR) and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (for example, because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SPRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can be commissioned jointly to reduce duplication of work for the organisations involved.

Consideration should also be given to ensure that there is no prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and the relevant family members. Guidance is available using this link to 'Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews' May 2014 https://www.cps.gov.uk/sites/default/files/documents/publications/liaison_and_information_exchange.pdf

In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child SPR or DHR, a criminal investigation or an inquest it will be essential to liaise with the Police Senior Investigating Officer where there are criminal proceedings ongoing to prevent interference with that process.

It may be helpful when running a SAR and DHR or child SPR in parallel, to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. 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. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

Further information can be found in form SAR 4b (Parallel process guidance) appendixed to this protocol.

9. Analysis

Analysis should be undertaken ensuring that it seeks out causal factors and systems learning but should also seek to identify areas of good practice that may need to be replicated in others areas. It should show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice. Techniques should be used that ensure that bias is kept to a minimum and which allow a transparent working out of conclusions in order for these to be critiqued. The analysis should be undertaken against a backdrop of the most up to date research in respect of good practice.

10. The Report (If this forms part of the review process)

SAB members should ensure that any report achieves its commissioned specification, captures the learning for organisations or partnerships and that it provides insight into factors that may prevent or hinder individuals from being safeguarded. The SAB members should also ensure that the level of details in the report satisfies the need for privacy by the adult or their family.

11. Improvement Action

The SAB should ensure that it enables robust, informed discussion and agreement by agencies of what action should be taken in response to the Safeguarding Adult Review (SAR) report. Decisions should be made in respect of individuals, agencies or forums who are able to tackle the systems findings raised and consideration should also be given to which factors can best be addressed locally, regionally or nationally.

SSASPB SAR Procedure:

12. Making a referral

Any agency, professional or other individual must refer a case believed to conform to the Safeguarding Adult Review criteria set out above. A referral must be made using the Safeguarding Adult Review Referral Form (SAR 2). This must include a synopsis of the case that will be shared with Board members and senior manager authorisation and will be submitted to the SSASPB Manager at SSASPB.admin@staffordshire.gov.uk.

It is essential that the referrer completes all of the boxes, particularly section (v), where they must provide detail of how they believe each separate criterion is met; this is to assist any future scoping panel in their decision making. Of particular note is the requirement for there to be concerns about how agencies worked together. The referrer must outline why they believe this criterion to be met and provide details of the agencies concerned.

Where the referral does not include sufficient information to inform decision making this will be returned to the referrer and approving manager before any further action is taken by the Board.

To prevent the sharing of personal details to individuals and organisations who will not be involved in any potential SAR the referrer must make every effort to include a list of known agencies that should hold relevant information on the adult named in the referral. It is important that personal details are not shared with anyone who won't be involved in the process.

13. SAR Decision making process (from point of accepting a referral)

i. Submission to SAR Sub-Group

The fully completed SAR referral from will be agendered at the next SAR sub-group meeting for consideration under the standing agenda item. If for any reason the discussion needs to be sooner an extraordinary SAR sub-group meeting may be called. Initial scrutiny at SAR meetings guards against placing unnecessary demands on partners in acknowledgement of the expected commitment and significant resource from partners where thresholds are met, or significant learning is identified in filtering processes. The SAR Sub-Group must consider any referral in the first instance to filter out those that clearly will not meet the criteria. Where a decision cannot be reached due to limited information this should be fed back to the referrer and further information provided and any resubmission ratified by the organisation's manager.

Where members agree that a referral does not meet the criteria for a SAR this will be recorded along with the rationale within the SAR Sub-Group minutes and the Board Manager will notify the referrer of this decision. It may be appropriate to suggest that the referring agency could undertake their own review.

Where members agree that the information included in the referral and initial information requests warrant further investigation, or where there is any uncertainty amongst SAR members a case would then be progressed to a Scoping Panel. When it is appropriate to do so the SSASPB Manager will arrange for family members to be contacted at a point agreed by the Scoping Panel.

ii) Information security

Once it is known that a case is to be considered at a Scoping Panel each agency should secure its records relating to the case to guard against loss or interference. It is each individual agency's responsibility to ensure there are internal processes in place that enable paper and electronic files to be secured whilst still enabling professionals to carry out their duties.

All agencies also have a responsibility for promoting confidentiality and sensitivity in the co-ordination and overall management of the review process. All reports must indicate their confidential nature and be password protected in accordance with each agency's information governance procedures. No personal data should be shared with any person or agency that is unlikely to hold relevant information. Anyone receiving a request to check records and find that nothing is held must advise ssaspb.admin@staffordshire.gov.uk that this is the case and then immediately delete the request and any associated emails.

Information sharing may take place under General Data Protection Regulations (GDPR) as SARs are statutory reviews and don't apply to persons who are deceased. The SSASPB will always take a proportionate stance on information sharing and will ensure that all personal information is shared via secure means.

iii) Chronology request

It is essential that the initiating referrer takes steps to identify which agencies are likely to hold relevant information to assist with the scoping process. All agencies that hold information relevant to the Scoping Panel Meeting will need to prepare a chronology, SAR 3 (b), covering their agency's activity which will be shared with the other agencies involved at the scoping panel meeting. Experience suggests that it is good practice to share all chronologies in advance of the scoping panel meeting.

Any chronology should capture significant events and representatives should be prepared to critique and comment on their own agency's practice. All documents submitted for consideration at the Scoping Panel should be approved and signed off by an appropriate line manager and, preferably, a Board member prior to submission to ssaspb.admin@staffordshire.gov.uk

There must be sufficient detail for the members of the Scoping Panel Meeting to make a recommendation as to whether or not there should be a SAR and if so the terms of reference and time parameters. Further guidance on completing a chronology can be found in SAR 3(b).

A copy of the chronology must be sent to ssaspb.admin@staffordshire.gov.uk by the advised date in order to provide other Panel members with a clear account of the agency information being shared at the Scoping Panel Meeting. It is essential that a secure e-mail is used to send the chronology which should also be password protected. Any correspondence must be marked as confidential.

iv) Scoping Panel

A Scoping Panel Meeting will be convened and will be chaired by the SAR Sub-Group Chair or Deputy. Where appropriate, members of the SAR Sub-Group will be core members of the Scoping Panel. Additional members may be co-opted by the Chair for their skills and experience relating to the individual case. Attendance will be required from each agency holding information, usually a manager who has no direct involvement with the case in question.

The role of the Scoping Panel Meeting is to:

a. review the information known to relevant agencies

b. determine whether or not the criteria for a SAR has been met

c. make recommendations to the Independent SSASPB Chair for final decision

v) Recommendation to SSASPB Independent Chair

The Scoping Panel meeting should, wherever possible, aim for a unanimous recommendation to be made to the SSASPB Independent Chair; the multi-agency nature of a Safeguarding Adult Review is such that it is important that the way forward is agreed as a partnership.

Should the decision not be unanimous then the number of voters saying that the SAR threshold is met and the number who didn't think so will be included in the recommendation to the Independent Chair. The Independent Chair will then consider the comprehensive minutes from the scoping panel and make their decision. The Independent Chair may or may not agree with the recommendation.

Where the Independent Chair disagrees with the recommendation then the reasons will be sent in writing to the scoping panel members, the referrer and SAR sub-group.

A Safeguarding Adult Review Criteria Document (SAR 4a) is available to assist Scoping Panel members in their considerations.

If the finding of the Scoping Panel Meeting is that the criteria for a SAR is **not** met **and** the Independent SSASPB Chair agrees the SSASPB Manager will write to the referrer informing them of this decision and rationale.

If the findings of the Scoping Panel Meeting are that the criteria is met and there **should** be a SAR under Section 44 (1) Care Act 2014, or the criteria is not met but there are lessons to learn under Section 44 (4) Care Act 2014, the Scoping Panel will consider and recommend:

a) terms of reference and scope of the review

b) the proposed methodology

14. Conducting a Safeguarding Adult Review

Review options and scope

The Scoping Panel Meeting will propose the terms of reference and scope of the review. These are outlined in SAR 4c and will be considered by the Independent SSASPB Chair who may amend them prior to approval. The SSASPB Manager will forward the recommendations of the Scoping Panel Meeting in writing to the Independent SSASPB Chair for final decision about how to progress the

matter. This decision will be confirmed in writing to the SSASPB SAR Sub-Group and the SSASPB will be updated. The SSASPB Manager will be responsible for informing the referrer and the agencies/individuals involved.

There will be a need to consider the budgetary requirements for undertaking a SAR or other review process and this will be the responsibility of the SSASPB. It is important that the intensive resources required for an effective SAR are only used to ensure the greatest learning and multi-agency practice development for the partnership. 'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' (March 2013)[1] provides some clarity in relation to this issue:

"Cost effectiveness is an issue for Safeguarding Adults Boards as an independent commission can prove expensive and, in some areas, there is an all-or-nothing approach to commissioning reviews. Some Boards, and very recently all the London authorities, have developed a ***proportionate approach*** *which offers Boards a range of options to match against the seriousness and circumstances of the case, allowing a faster and more cost effective response while maximising the Board's learning."*

Methodology

Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options some of which are highlighted below and summarised in SAR 4d:

This is not an exhaustive list

a) Review by Independent Author and the production of an overview report

b) Action learning process

c) Peer review process

d) Significant event analysis

e) Multi-agency combined chronology/learning review

f) Single agency review process

g) Case file audit

h) Tabletop exercise

i) It is possible for the scoping panel to agree that the scoping exercise has been sufficiently thorough and that the process undergone should be considered a SAR in itself under Section 44 (1) or Section 44 (4) of the Care Act 2014. This option is only to be utilised if the actions for improvement are clear, agreed, not overly complex, achievable and there is unanimous agreement that it is an appropriate methodology with regards to the circumstances of the case discussed.

The decision on the type of overview report will be considered on a case by case basis, if an Independent Reviewer is appointed there will usually be a full overview report and an executive summary. In any review the SAR scoping panel will appoint critical friends, these critical friends will not be from the agencies involved with the Adult and it is their function to provide independent scrutiny and challenge which will be recorded.

If a single agency review process is thought to be beneficial whether as part of or instead of a SAR, the SAR review panel will formally advise the organisation of this recommendation. Should the organisation decide not to conduct a single agency review then the reasoning will be forwarded to the SAR review panel where the request will be re-assessed, and a way forward agreed. If agreement cannot be reached, then the Board escalation policy will be utilised.

Format of a review by Independent Author

Should the decision be to commission a review by an Independent Author then the following process will be followed;

Administrative arrangements

The Chair of the SSASPB SAR Sub-Group, in conjunction with the SSASPB Manager, will be responsible for ensuring administrative arrangements are completed and the review process is conducted according to the stages described below.

- Evidence and information collection
- Receipt of evidence (Review Panel)
- Report to Board with review recommendations
- Development and monitoring of action plans

Tendering/Commissioning an Independent Author

When commissioning an independent reviewer to undertake a SAR, consideration should be given to an individual's experience and expertise in this area, which may include seeking testimonials from previous commissioners/Boards. Flexibility to select an independent reviewer without the necessity of a lengthy selection process should be the norm. However, where the case to be reviewed is believed to be complex consideration should be given to forwarding a brief synopsis of the case to three independent authors seeking methodology and costs for comparison. The SAR Sub-Group will make a recommendation to the Executive Sub-Group for approval which maybe done electronically to prevent delay.

The Reviewer will be wholly responsible for their own personal taxation responsibilities.

The Reviewer will give assurance that they understand the requirements of the General Data Protection Regulations and how it impacts on the retention of any information stored by them connected to the SAR.

SAR Review Panel

A Review Panel will be convened and will usually be chaired by an Independent Reviewer if appointed, the SAR Sub-Group Chair or other member, or someone else not connected to the SSASPB but with experience in conducting SARs or Serious Case Reviews (where complete independence is desired). The Chair will be responsible for ensuring that all agencies are properly represented at the Review

Panel and that they contribute to the process, completing any tasks in the timescales agreed, and reporting any lack of engagement or other blockages to progress to the SSASPB.

As an agreed principle, core membership of Scoping and Review Panels is drawn from members of the SAR Sub-Group to enhance their experience. Non-contributing agency SAR Sub-Group members are invited to act as Critical Friends, enhancing their experience and ensuring the integrity of the process and its adherence to the SAR Protocol. The Review Panel will be made up of representatives from the agencies to whom the adult was known but who have not had any direct management or involvement in the case. Additional members may be co-opted by the Chair, e.g. Board members not involved in the case for their independent scrutiny and challenge or individuals for their skills and experience relating to the specific case. The relevant Local Authority may be asked to consider inviting a representative from their legal team to attend meetings and advise the Review Panel on legal aspects of the case. The SSASPB has agreed to set aside a budget to fund any legal advice that is required and provided by either Local Authority. The legal advisor will not then provide legal advice to the Local Authority to prevent any conflict of interest.

The Review Panel will confirm the terms of reference of the case, propose timescales for completion and consider how the adult, their family and/or representative will be engaged and any likely media interest.

It may be helpful to distribute the minutes from the scoping panel meeting with the papers for the first review panel meeting.

The Review Panel will meet as required to review progress and at significant points in the process. They will note any areas of learning and acknowledge any examples of good practice identified through the review. The SAR Sub-Group Chair will provide progress updates to the SSASPB.

The Review Panel will consider whether there are links to other constituted Boards, e.g. Local Safeguarding Children Partnership Boards (LSCPs), Responsible Authorities Group (RAG) etc. or cross-boundary issues and whether an appropriate representative should be invited to the group. Should information regarding significant individual and/or organisational omission be received that requires notification to a statutory body, the relevant agency will ensure this is completed without delay.

The review panel will consider how to engage with the family, carers or advocates at the first meeting.

The review panel will determine whether or not the review is to be published. It is expected that all Statutory SARs will be published unless there is a good reason not to. This decision will be made on a case by case basis and it is only in exceptional circumstances that a review is not published.

Implementing Review Recommendations

Where the methodology includes a final report that final report and recommendations will be presented to Board members. An extra-ordinary Board will be arranged where there is a significant period until the next scheduled meeting or the agenda does not allow sufficient time to receive the report.

The final report and recommendations will be presented to the SSASPB, which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented

- Consider the completion of an (anonymised) Executive Summary that includes key learning points for agencies and would be suitable for publication
- Consider how the full report/Executive Summary will be published and notified to interested parties and the media
- Agree mechanisms for dissemination of the full report/Executive Summary to the adult, their family and/or representative, professionals or any other interested party.

The SSASPB Manager will:

- Disseminate the full report (if agreed)/Executive Summary and key findings to relevant interested parties including the agencies involved in the case
- Seek assurance that agencies provide feedback to staff as appropriate
- Make arrangements for the publication of the full report/Executive Summary as agreed by the SSASPB ensuring that lessons learnt are published on the SSASPB website
- Formally conclude the review process when the recommendations have been accepted, Action Plans submitted to the SAR Sub-Group and actions signed off as complete.
- Notify any formal body as appropriate
- Ensure that any SAR undertaken is referenced in the SSASPB Annual Report (in the year that the SAR is concluded) including what action has been taken, or is intended to be taken. Where the SSASPB decides not to implement an action from the findings of a SAR it must state the reason for that decision in the Annual Report.

Action Plan

Following the acceptance of a final report and recommendations, the SAR Sub-Group will agree an Action Plan using SAR 5a – which will outline:

- Who will be responsible for various actions
- The timescales for completion of agreed actions
- The intended outcome and purpose of recommended actions

Progress against actions will be reported to and monitored by the SAR Sub-Group who will in turn escalate by exception to the Executive Sub-Group.

15. Communication

i. Media

It is critical that there is a cohesive approach and response to media enquiries resulting from a Safeguarding Adult Review and that the SSASPB and individual agency leads act in consultation.

It will generally be the case that where there is an ongoing criminal investigation the police will be the lead agency and otherwise it will be the most appropriate agreed agency, usually the Local Authority.

Any publication arrangements and media strategy will be agreed by the SSASPB Review Panel (if relevant), the SSASPB Independent Chair and the relevant Local Authority Lead member. If required, the Independent Chair together with the lead member will normally act as the spokesperson on behalf of the SSASPB.

ii. Escalation

Where there is challenge to matters relating to the SAR Protocol or process, concerns should be communicated to the SSASPB Manager who will raise these for discussion within the most appropriate forum e.g. Review Panel, SAR Sub-Group, Executive Sub-Group etc.

The SSASPB Independent Chair will have the final judgement where there are concerns or challenge in relation to a recommendation from the Scoping Panel. In circumstances where an adult involved in the review, their family or advocate, challenges the decision made about whether or not a SAR is to be undertaken, they will be advised to make their representations to the relevant ombudsman.

Where the threshold is met but there is challenge to the proposed course of action e.g. methodology of a SAR, this will be escalated to both the Independent Chair and SAR Chair, or to Executive Sub-Group members as appropriate.