Dorset Safeguarding Adults Board
and
Bournemouth, Christchurch & Poole Safeguarding Adults Board

Safeguarding Adults Review Policy

Version Control

Version number	Purpose of the change or details of the change	Person making the change	Date
1.0	Initial Policy Agreed May 2015		
2.0	Revised Policy	Siân Walker-McAllister	September 2021

Dorset Safeguarding Adults Board
and
Bournemouth, Christchurch and Poole Safeguarding Adults Board
Safeguarding Adults Review Policy

Contents

1. Introduction

Section 44 of the Care Act 2014 and associated statutory guidance requires all Safeguarding Adults Boards (SABs) to conduct Safeguarding Adults Reviews (SARs) (previously known as serious case reviews) in certain circumstances and permits SABs to arrange SARs in other circumstances. The Act requires Board member agencies to cooperate with and contribute to the carrying out of a SAR.

"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."

Care and Support Statutory Guidance (DH: 2010) paragraph 14.135.
Care and support statutory guidance - GOV.UK (www.gov.uk)

SABs must arrange a Safeguarding Adult Review 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.

SABs must also arrange a Safeguarding Adult Review 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 Safeguarding Adult Reviews, 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. SABs are free to arrange for a Safeguarding Adult Review in any other situations involving an adult in its area with needs for care and support.

No single review model will be applicable for all cases: review methodology should be determined by the circumstances of each case.

Safeguarding Adults Reviews may be complex and detailed or may take account of other reviews undertaken (whether statutory or not). They are undertaken for the purpose of understanding and learning from individual cases to continuously improve the effectiveness of the wider system. They are reserved for situations where there is potential for extensive systemic learning due to serious questions about the multi-agency system as a whole.

2. Purpose of Safeguarding Adults Review (Learning not blaming)

The purpose of holding a Safeguarding Adult Review is not to reinvestigate or to apportion blame; it is concerned with preventing future deaths/serious abuse, harm or neglect occurring again.

Safeguarding Adult Reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented serious abuse, harm, neglect or death. This is so that lessons can be learned from the case and applied in future to prevent similar harm from occurring again.

The purpose of a Safeguarding Adult Review is not to hold any individual or organisation to account – other processes exist for that purpose which include each partner organisation's own disciplinary procedures – but to focus on the learning.

Where relevant, organisations should contact their governing/regulatory body and ensure that communication about the events leading up to the SAR is transparent.

3. Criteria for Safeguarding Adults Review

3.1. A Safeguarding Adults Board is the only body that can commission a Safeguarding Adults Review. As set out in S44 of the Care Act 2014, a SAR must take place when:

- an adult 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.
- adult has experienced serious abuse or neglect, but has not died

3.2. "Serious abuse or neglect" may include:

- the individual would have been likely to have died but for an intervention,
- the individual suffered permanent harm as a result of abuse or neglect,
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.
- the individual has sustained a potentially life-threatening injury through abuse or neglect,
- the individual has suffered serious sexual abuse.
- This is not an exhaustive list. The final decision rests with the LSAB or delegated SAR panel as to whether abuse/ neglect was serious enough to warrant a SAR.

3.3. In addition, Safeguarding Adults Boards are also free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

3.4. There is no requirement for a case to have gone through a Section 42 safeguarding adults' enquiry before it can be considered for a SAR.

3.5. A discretionary SAR should only be commissioned when there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future.

3.6. Appropriate cases for a discretionary SAR may include:

- Serious incidents that do not meet the criteria for a SAR but that the SAB wants to review.
- A case featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.
- The criteria for carrying out a Safeguarding Adult Review is broad and therefore the approach taken should be proportionate according to the scale and level of complexity of issues being examined. A SAR can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults or explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

4. Learning that the Safeguarding Adults Review needs to accomplish

In any Safeguarding Adult Review there is a need to achieve an understanding of:

- What happened?
- Any errors, absence of good practice or problematic practice and/or what could have been done differently?
- Why those errors, absence of good practice or problematic practice occurred and/or why things did not happen differently, for example any systemic issues preventing good practice?
- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become recommendations for learning?
- Whether any of the issues identified were also present in previous reviews and, if so, whether steps have already been taken to improve practice as a result?

- What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases?

All Safeguarding Adult Reviews should present clear and concise findings taken from the 'Information Management Reviews' (IMRs) and chronologies, responses to queries and questions and analysis by the author.

All Safeguarding Adult Reviews must identify clear, specific, measurable and, realistic recommendations for individual agencies and for the SAB.

5. Making a decision on SAR Methodologies

A range of methodologies or tools can be used to undertake the necessary investigations to deliver a Safeguarding Adults Review.

No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding and remedial action. There must always be a consideration of how family and friends can achieve clarity and understand what happened. Whilst this is not the primary function of a Safeguarding Adult Review, there must always be a consideration of involvement of individuals and families or significant others as appropriate, in contributing to a Review.

The Safeguarding Adults Board Sub-Group will agree:

- The type of 'review' process and methodology to be used.
- The arrangements for governance of the review and overseeing its development as well as agreeing the draft final review to be placed before the Board for consideration.
- The most effective way to promote learning and improvement action.
- Consideration of how the SAR may also be used to explore examples of good practice where this is likely to identify lessons that can be applied in future.

The following principles should be applied by the Safeguarding Adults Board Subgroup to all reviews:

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined and will be overseen by the Board through its delivery of a Review and Action Plan.
- When the SAR criteria are met, consideration should be given to other statutory and non-statutory reviews which are taking place simultaneously or may have precedence. If other partner organisations' reviews (e.g., Mental Health Homicide Review, Domestic Homicide Reviews, NHS Serious Incident Reviews or Review by a partner in accordance with their own organisational policies) is taking place, then a decision can be made to put the SAR on hold until the outcome of that review. Additionally, and in some circumstances, it may be appropriate to have sight of the Terms of Reference for that Review and for a request to be made to include issues which might be pertinent to a SAR. In such cases, the other completed Review may be brought back to the SAR Subgroup to then decide whether in fact more work needs to be undertaken or whether the Review as it stands can be considered for a SAR to place before the Board. (See also Point 7 below)
- Reviews of cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed (not necessarily an independent overview author).
- Relevant professionals should be involved fully in reviews and invited to contribute their perspectives.
- Where possible, adults at risk are to be involved in a Safeguarding Adult Review, to make a contribution about their own experience. If they have any significant difficulty in being involved an advocate may help them to be as involved as far as possible in the process.

- Families should be invited to contribute to reviews, where appropriate. They should be informed when a Review has been commissioned and the SAR Subgroup Chair or another appropriate person such as an involved professional should clearly communicate with them so that they understand how they are going to be involved. Their expectations should be managed appropriately and sensitively.

The options for conducting a Safeguarding Adult Review are detailed in the appendices, as are the skills required of a SAR Author.

6. Timescales

In general, SARs should be completed within 6 months, unless otherwise specified.

7. Joint Reviews

The SAR subgroup will seek to identify at the outset what other reviews and processes are taking place or envisaged in relation to the same events. Where there are possible grounds for a Safeguarding Adults Review and a Domestic Homicide Review or Safeguarding Children Serious Case Review, Multi Agency Public Protection (MAPPA) Serious Case Review, Mental Health Homicide Investigation and/or other such formal review processes, then a decision should be made at the outset by the decision makers involved as to:

- which process is to lead
- who is to take which role
- who is to chair with a final joint report being taken to the necessary commissioning bodies

Whether some aspects of the reviews can be commissioned jointly should be considered so as to reduce duplication for families and professionals. It will be important that terms of reference for related reviews effectively cover all aspects of the case.

Similarly, NHS bodies carry out Serious Incidents Requiring Investigation (SIRI) and any relevant investigation, which meets the criteria for a SAR, should be shared with the Safeguarding Adults Review Subgroup in order to make best use of resources and information.

Any Safeguarding Adult Review 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 delays in the review process and in order not to compromise information which can be made available.

A coroner is legally entitled to require information provided to Safeguarding Adult Reviews as well as the overview report itself. When a Coroner requires information, correspondence will be with the Chair of the Safeguarding Adults Board.

8. Process for Initiating a Safeguarding Adults Review, Complaints and Appeals

Anyone e.g., a member of the public, agency or professional body, elected members, MPs or a Coroner may refer cases to the SAB for consideration for a SAR. Referrals must be made in writing to the Board Business Manager who will bring it to the attention of the SAR Subgroup Chair and the Chair of the Board. The SAR Sub-Group will decide, if a review should be recommended (see Appendix 6 Safeguarding Adult Review (SAR) Request Form for relevant forms).

The SAR subgroup acts as an advisory group to the SAB Chair who is responsible for making the decision to recommend to the Safeguarding Adults Board whether to proceed with a review or not.

The Safeguarding Adults Board is responsible for commissioning Safeguarding Adult Reviews.

A decision about whether to undertake a Safeguarding Adult Review should be made within 6 weeks from receipt of the initial request. The Chair of the SAR subgroup will advise the person making the referral, in writing, of the decision whether to proceed with a SAR.

8.1 Appeals - In the event of a decision being made that the matter does not meet the criteria for a SAR, the reasons need to be recorded by the Chair and shared with the referrer.

If the referrer wants to appeal against a decision not to carry out a Safeguarding Adult Review, it should be put in writing to the Independent SAB Chair, who will review the decision. The SAB Chair may take legal and other professional advice and s/he will write to the referrer setting out why the referral did not meet SAR criteria or, whether the matter has been reconsidered and explaining what other actions may be taken.

9. Annual Report and SAR Outcome Reporting

The Safeguarding Adults Board must include information about the findings from any Safeguarding Adult Review in its Annual Report and what actions it has taken or intends to take in relation to those findings. Where the Safeguarding Adults Board decides not to implement an action then it **must** state the reason for that decision in the Annual Report.

10. Additional Considerations for a SAR which will be Determined by the SAR Panel

There will be a need to identify the budgetary requirements for undertaking a Safeguarding Adult Review, which will be the responsibility of the relevant Safeguarding Adults Board. Where a Joint Review takes place each organisation's contribution should be agreed at the outset.

Agencies should adhere to the Pan-Dorset Overarching Information Sharing Agreement and Board's Personal Data Exchange Agreement.

All agencies must ensure that information, including accurate and secure records, required for delivery of the SAR are available for the SAR author, in the time required as requested by the SAR Panel.

Relevant legislation for example the Care Act 2014, Mental Health Acts and Mental Capacity Act 2005 must be adhered to.

The SAR Panel will agree with the SAR Subgroup Chair a list of issues to be included in any media and communication strategy. The strategy will be agreed between the SAR Subgroup Chair and the SAB Chair.

11. Terms of Reference for SAR Meetings

The terms of reference for the Safeguarding Adult Review subgroup are listed in Appendix 1.

The terms of reference for a Safeguarding Adult Review panel are in Appendix 2.

12. The Process – See Appendix 5 SAR Process

13. Commissioning a Lead Reviewer/Author

The SAR Sub-Group will select an appropriate Author/ Lead Reviewer from the preferred provider list – chosen with the most appropriate skills which are required for a particular SAR.

The SAR Author/ Lead Reviewer will be given copies of the SAR Policy together with the proposed Terms of Reference for the SAR and dates will be set out for attendance at the various SAR Panel Meetings.

The person leading the review will be expected to attend a meeting of the SAB to present the final draft report and will also be expected to produce an Executive summary.

SARs must be of high quality and demonstrate value for public money. Where the methodology selected is suitable, a Panel Chair with the appropriate expertise will be appointed. Procurement will be in accordance with the financial rules of the lead authority.

Once the report is written, the person leading the review is responsible for seeking agreement from all contributing agencies that they are satisfied that the report reflects the information shared and discussions held as part of the review. If it is not possible to obtain agreement, the person leading the review and the SAR Subgroup Chair take the final decision on the report content. The Chair of the SAB should be notified where agreement has not been obtained from all agencies

14. Action Plans and Recommendations following a SAR

Action plans resulting from a Safeguarding Adult Review recommendation need to be SMART with robust outcomes that can be monitored and measured.

- They should be clearly achievable within timescales considered
- Consideration should be given as to whether the action plan is also published with final report on the Board website, if the full SAR is published

The SAR Subgroup will need to include a Draft of the SAR Action Plan to be submitted to the Board for decision alongside the final Draft SAR report.

Completion of actions in the plan will be monitored by the SAR subgroup and reported regularly to the SAB. A review will only be closed when the SAB is satisfied that all the actions have been completed. The relevant Board subgroups will determine if there should be any longer term follow up of the impact on practice of the recommendations of the review as part of its annual audit plan.

15. Learning and Dissemination following a SAR

Learning and dissemination of learning from Safeguarding Adult Reviews will be led by individual agencies with oversight by the appropriate SAB subgroup. A range of methods for disseminating and briefing staff will be used, including formal learning events, on-line learning and 7-minute briefings. Any new learning will also be integrated into regular adult safeguarding training programmes.

Each partner agency will be asked to assure the SAB that they have allocated sufficient time and resource for staff to integrate the lessons into practice.

16. Publication

SARs will usually be published and placed on the SAB website. Where there are exceptions to publication, e.g., to protect anonymity of the subject or their family members, these will have been agreed by the SAB at the time the SAR was presented and agreed.

In all circumstances and in particular where there may be public interest in the findings of a review the Board will take a more proactive stance and in line with a Media Communications Strategy take the appropriate steps. In these circumstances the SAB will work alongside and expect that partner Communication Leads are proactive and working together with one Lead Agency with joint press release and FAQs. The Chair of the Board will act as the spokesperson on behalf of the Board.

Appendix 1 Terms of Reference for a Safeguarding Adult Review Subgroup

The Safeguarding Adults Review subgroup (SAR subgroup) is a sub-committee of both the Bournemouth Christchurch and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board and has powers specifically delegated in these terms of reference.

1. Purpose

To oversee Safeguarding Adults Review functions on behalf of Bournemouth, Christchurch and Poole and Dorset Safeguarding Adults Boards consistent with the Boards' Safeguarding Adults Review Policy and to ensure they are consistent with national guidance and any relevant local policies.

To set up a Task and Finish Group called the Safeguarding Adult Review Panel that would carry out Safeguarding Adult Reviews in accordance with Section 44 of the Care Act 2014.

2. Objectives

- To establish the Terms of Reference for each of the SARs commissioned and to determine whether there are lessons to be learned from cases under review or that could be under review; about the way in which local professionals and agencies work together to safeguard adults

- To commission SARs which establish what those lessons are, how they will be acted upon and what is expected to change as a result.

- To provide effective governance of the SAR process where the outcomes are likely to improve inter-agency working and quality of safeguarding interventions.

- To enable effective communication between all stakeholders to ensure the learning from reviews is widely disseminated

- To establish appropriate contact with family members and to ensure that they are informed and involved in the way they wish to be.

3. Specific Remit/Duties

a) Secure compliance with the Dorset Safeguarding Adults Board and the Bournemouth, Christchurch & Poole Safeguarding Adults Board Safeguarding Adult Review Policy

b) Keep the Safeguarding Adult Review Policy (including criteria for reviews) under review; advise the Board on its effectiveness and best practice in the conduct of Safeguarding Adult Reviews.

c) Receive, screen and consider review requests against agreed criteria and make recommendations to the Board Chair on the need and type of Safeguarding Adult Review; to include the methodology used.

If the criteria for a Safeguarding Adult Review are not met then the subgroup may take other approaches as follows:

- If it is felt that there could still be important learning to be derived from a more proportionate review of a case, this can be referred to the Safeguarding Leads meeting which will report back to SAR subgroup and then the Board.
- If the case involves actions by a single agency, then the SAR subgroup can seek assurance and request feedback from the organisation as to improvement actions taken.
- If a case is already being reviewed by another partnership, for example LeDeR, the subgroup can request information concerning the outcome of that review.

d) Identify learning points from Safeguarding Adult Reviews and report on outcomes to the Safeguarding Adults Boards

e) Ensure confidentiality is maintained in relation to information for Safeguarding Adults Reviews within the parameters of the Personal Data Exchange Agreement is adhered to

f) Work with the SAB Chair and the Board to ensure communication with and briefing to staff, family members and media as appropriate.

g) Promote transparency and objectivity and ensure declarations of interest and any conflicts of interest are identified at all meetings and during reviews.

h) Clarify, advise and make decisions on the sharing or dissemination of reports (in whole or in part).

i) Ensure involvement by or with other relevant bodies e.g. CQC, Home Office, Coroner and any other relevant professional, government and inspection bodies as required by individual agencies.

j) Report quarterly to the Bournemouth, Christchurch and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board.

k) Maintain a forward plan of work and set time aside each year to:

- Review achievements and improvements.
- Assess effectiveness.
- Consider future requirements.

4. Membership of the SAR Subgroup

Chair and Deputy Chair to be agreed by the joint Boards' meeting

Membership will include:

- Bournemouth, Christchurch and Poole Council adult social care
- Dorset Council adult social care
- Dorset Clinical Commissioning Group
- Dorset Police
- Representative of the 2 Community Safety Partnerships as appropriate to the agenda
- Business Manager of each Safeguarding Adults Board

Representatives of other organisations may be invited to the subgroup to participate in discussion, support decisions and provide information about specific cases.

5. Quorum/Voting

For the sub-group to be quorate, membership must include representation from each of the statutory partners, plus a Business Manager and the Chair or Deputy Chair

6. Organisation, Frequency of Meetings, Administration

Meetings to be arranged every six weeks – may be cancelled if insufficient business. Administrative support will be arranged by the Business Managers

7. Standing Agenda Items

- Welcome and Apologies
- Minutes and Matters Arising
- Safeguarding Adult Reviews – progress and updates
- Requests for new Safeguarding Adults Reviews
- Progress on Action Plans
- Dissemination
- Any other Business

8. Relationships with Other Committees

This Safeguarding Adult Review subgroup reports to and is a subgroup of the Bournemouth Christchurch and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board.

For each SAR, the subgroup sets up a time-limited Task and Finish group (known as the Safeguarding Adults Review Panel) to oversee work on a Safeguarding Adult Review using the methodology agreed with the lead reviewer.

Where a referral does not meet the criteria for a Safeguarding Adult Review the subgroup may request that the Safeguarding Leads Group explores and reports back on any learning from the case.

9. Monitoring Effectiveness, Review Date

To be reviewed annually and as requested

10. Document Owner

Date	Contact	Version	Page	Details of Change

Appendix 2 Terms of Reference for the Safeguarding Adults Review Panel

The Safeguarding Adults Review panel is a subgroup of the Safeguarding Adult Review subgroup, which is accountable to the Bournemouth, Christchurch & Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board. It is a time-limited Task and Finish group formed to work on a particular case using the methodology agreed by the report author and the panel.

1. Purpose

To provide overarching governance to delivery of a Safeguarding Adult Review on behalf of the Safeguarding Adult Review subgroup of the Boards in accordance with Section 44 of the Care Act 2014 and with the Dorset, Bournemouth Christchurch & Poole Safeguarding Adults Review Policy.

2. Objectives

- To ensure the chosen methodology is applied to the report by the author to within the timescale agreed
- To ensure that accurate and timely information is provided for the SAR author and that there is good organisational governance supporting the information provided by agencies
- To provide governance for the progress of the SAR and to ensure that the author provides timely drafts of the report for consideration by the Panel
- To agree with the author and establish the lessons to be learned from the case under review, which will be reflected in recommendations for the SAB and for partner agencies

3. Specific Remit/Duties

a) Promote a culture of continuous learning across all the organisations taking part in the Review

b) Ensure compliance with the Care Act 2014 as it relates to the Dorset Safeguarding Adults Board and the Bournemouth, Christchurch & Poole Safeguarding Adults Board Safeguarding Adults Board

c) Focus on what needs to happen to achieve understanding, remedial action and a clear and transparent overview for family/friends of adults who have died or been seriously abused/neglected

d) Ensure the approach taken to reviews is proportionate according to the scale and level of complexity of issues being examined

e) Ensure that progress of the review is delivered and that all agencies are appropriately responding to queries and providing information in a timely manner

f) Ensure confidentiality is maintained in relation to information for Safeguarding Adult Reviews and that the parameters of the relevant Information Sharing Agreements are adhered to. All information circulated and discussed at the meetings are confidential to the panel membership unless agreed otherwise with the Chair.

g) Ensure that findings and learning is clearly identified within the Review

h) Advise the Safeguarding Adults Review subgroup on the development and content of the first draft of the SAR action plan.

4. Chair, Members, Administration

Chair & Members are to be nominated by the Safeguarding Adult Review subgroup. The Panel will also make arrangements with the SAR subgroup for notes to be taken at each meeting

5. Quorum

The panel acts as a working group to the Safeguarding Adults Review subgroup There is no specific quorum and there is an expectation that all panel members will attend for the duration of the Panel. If there are concerns about attendance or any issues under discussion cannot be agreed, the matter must be referred back to the chair of the Safeguarding Adult Review subgroup.

6. Organisation, Frequency of Meetings, Administration

Meetings to be arranged to fit the work programme agreed by the Safeguarding Adults Review subgroup.

7. Standing Agenda Items

- Welcome and Apologies
- Minutes and Matters Arising
- Progress on the Review and presentation of drafts and iterations of the Review report
- Any other Business

Appendix 3 Independent Lead Reviewer and Chronology

1. Conduct of Safeguarding Adults Review

1.1. Scoping Meeting – this will agree:

- The Terms of Reference for the Review
- The agencies, which should be asked to secure their case records promptly, complete an IMR and individual chronology, timescales covered, and the level of detail required.
- The "evidence" or information required from each participant.
- Time scales within which the review process should be completed.
- The nature and extent of legal advice required, in particular: Data Protection, Freedom of Information and Human Rights Act and Domestic Violence Crime and Victims Act 2004.
- The appointment & commissioning of the Overview Author

1.2. Briefing meeting – briefing Individual Management Report (IMR) authors.

- Each agency is required to complete an IMR and will inform the Subgroup Chair of the name of the IMR author(s).
- The IMR authors will be invited to meet with the Panel, to ensure the Terms of Reference for the Review are clear and to identify and resolve any barriers to completing the work.
- Ensure IMR authors have assistance or training if required
- The IMR Report proforma is attached at Appendix 7
- Where there has been limited engagement with the subject of a SAR a Summary Report proforma may be used in place of the IMR – see Appendix 8

1.3. Individual Management Reports

The IMR authors undertake the work and complete the IMR in a specified timescale, usually 6 weeks from scoping meeting.

1.4. Safeguarding Adults Review – receipt of information meeting or IMR Panel Day.

This stage of the meeting is a formal information-sharing session where agencies will be encouraged to query and comment on the reports presented. IMR authors will be invited to a meeting to clarify and raise queries from their reports.

Each agency involved, and IMR authors where appropriate, will be asked to:

- Present and examine the chronology of events, highlighting any discrepancies.
- Present a comprehensive report of the actions by their agencies.
- Ensure any other management reports and other relevant information is made available.

1.5. Safeguarding Adults Review – discussion of information or second IMR Panel Day.

This stage is where the assessment of whether any new information has come to light that warrants any further action. The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source.
- Examine and identify relevant action points.
- Form a view on practice and procedural issues.
- Agree the key points to be included in the report and the proposals for action.

1.6. Issues Arising

If, at any stage whilst undertaking the procedure contained in 7.4 and 7.5 information is received which requires notification to a statutory body regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

A decision will be made as to whether the Safeguarding Adults Review process should be suspended pending the outcome of such notification.

1.7. Report Stage

The review panel will complete the review of agency management reports and those commissioned from any other source and advise the Chair on the production of an Overview Report, which brings together information, analyses it and makes recommendations. The Chair will have commissioned an independent Overview Report writer and ensure that the Report is written and delivered within agreed timescales, usually 5 to 6 months from initial decision to proceed.

The Safeguarding Adults Review will consider, and quality assure the overview report to ensure it meets the required standard for the Safeguarding Adults Board.

1.8. Acting on the recommendations of the Safeguarding Adults Review

On completion, the Overview Report will be presented to the Safeguarding Adults Board, which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report.

- Ensure that the Overview Report contains an Executive Summary which can be made public and consider the need for a professional briefing paper with key learning points for agencies.

- Translate recommendations from the overview report into an action plan, which should be endorsed at senior level by each agency.

1.9. The action plan will indicate:

- Responsibilities for various actions.
- Timescales for completion of actions.
- The intended outcome of the various actions and recommendations.
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems.
- To whom the report or parts of the report should be made available and indicate the means by which this will be carried out.
- The processes for dissemination of the report and/or key findings to interested parties, for the receipt of feedback and for any debriefing to staff, family members and, where appropriate, the media.

1.10. Recommendations

- The Safeguarding Adults Board will ensure that all recommendations are actioned and will request updates from agencies.

- The Action Plan will remain on the Safeguarding Adults Board Agenda until such time as all recommendations have been implemented.

Appendix 4 - Skills required for a SAR Author

In all cases at least an author/ reviewer or report writer is required and in order for the review to be effective, the skills and experience expected of those undertaking a Safeguarding Adult Review need to include:

- Demonstrable and evidenced Report Writing Skills
- Strong leadership skills and ability to motivate others.
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
- Collaborative problem-solving experience and knowledge of participative approaches
- Good analytical skills and ability to manage qualitative data Good knowledge of the Care Act, Mental Health Acts, Mental Capacity Act and application of Safeguarding interventions.
- Commitment to promote an open, reflective learning culture.
- Evidenced experience of having written SARs or other reports requiring complex analytical skills

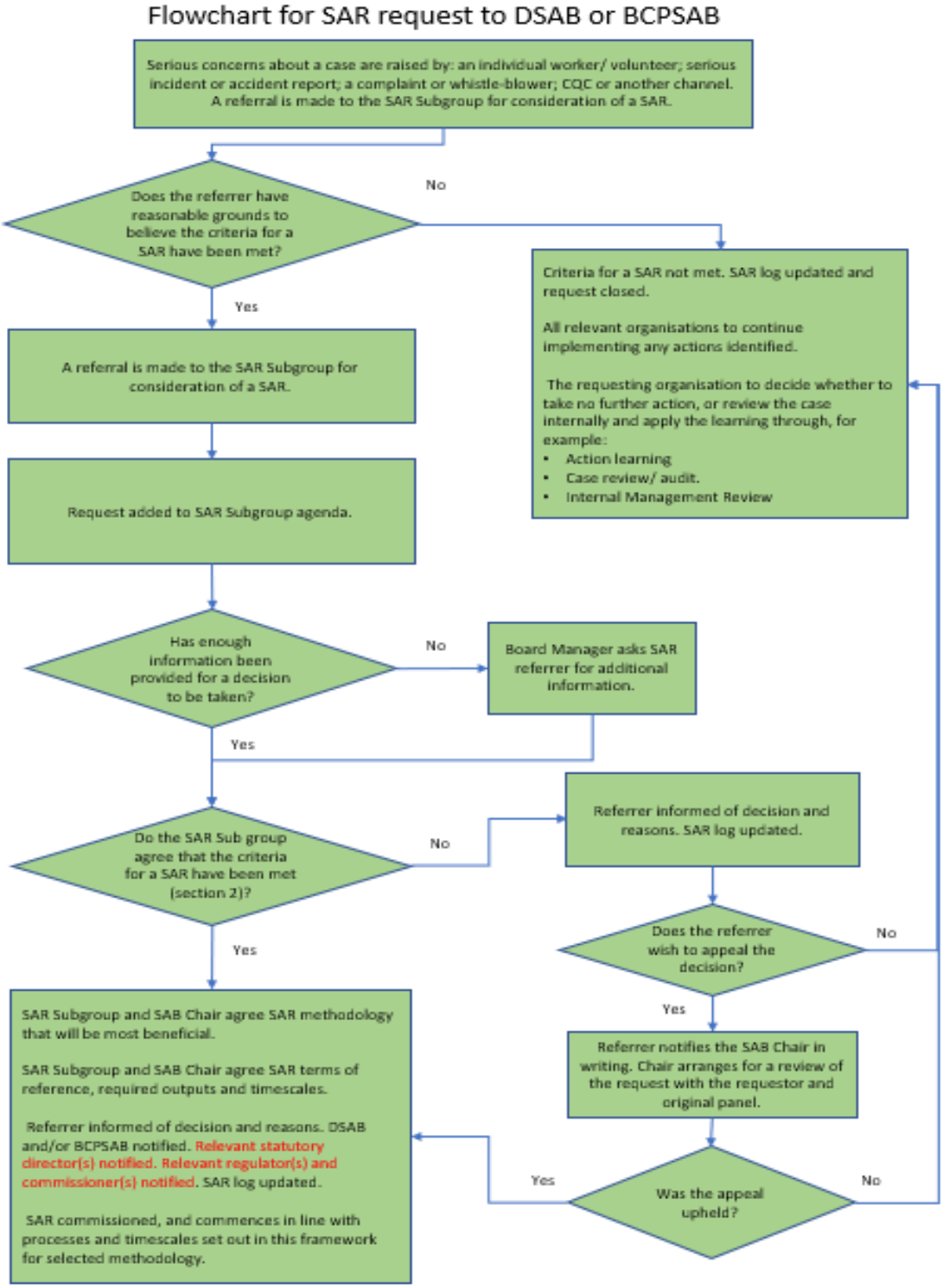
The Review must be written in plain English, always include the translation of acronyms, and include a Glossary at the end.

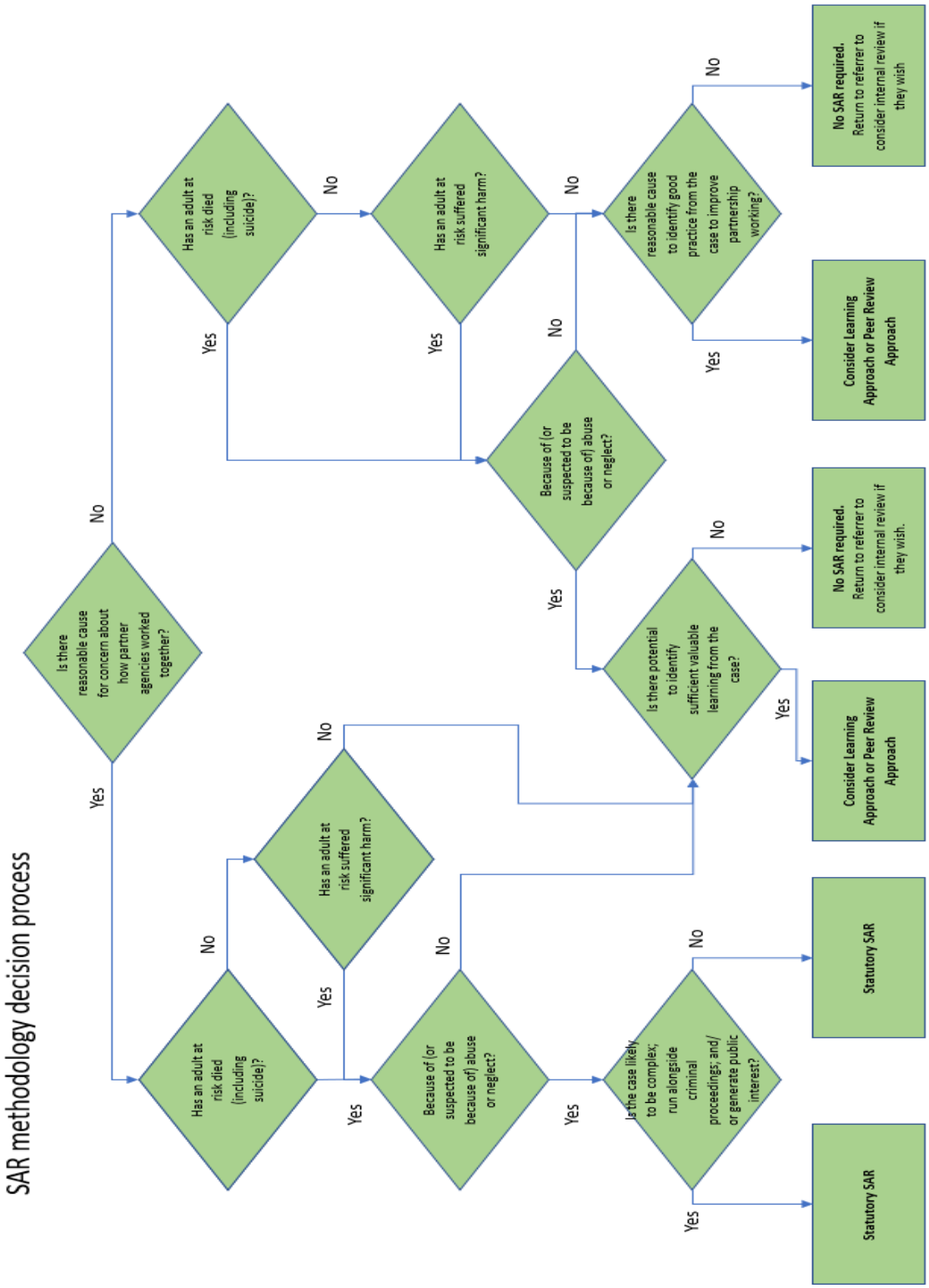
Safeguarding Adult Reviews should reflect the six safeguarding principles, (empowerment, prevention, proportionality, protection, partnership and accountability).

The Guidance requires the reviewer/s to be independent of the case (and the organisation) under review but not necessarily an external consultant, so salaried professionals in the local safeguarding network (but not involved in the case) may be appropriately appointed as the lead reviewer.

Cases that do not meet the SAR Criteria will be reviewed as appropriate by the SAR Subgroup or Safeguarding Leads.

Appendix 5 SAR Process




SAR methodology decision process
Is there reasonable cause for concern about how partner agencies worked together?
Yes
No
Has an adult at risk died (including suicide)?
Yes
No
Has an adult at risk suffered significant harm?
Yes
No
Because of (or suspected to be because of) abuse or neglect?
Yes
No
Is the case likely to be complex; run alongside criminal proceedings; and/ or generate public interest?
Yes
No
Statutory SAR
Statutory SAR
Has an adult at risk died (including suicide)?
Yes
No
Has an adult at risk suffered significant harm?
Yes
No
Because of (or suspected to be because of) abuse or neglect?
Yes
No
Is there potential to identify sufficient valuable learning from the case?
Yes
No
Consider Learning Approach or Peer Review Approach
No SAR required. Return to referrer to consider internal review if they wish.
Has an adult at risk died (including suicide)?
Yes
No
Has an adult at risk suffered significant harm?
Yes
No
Is there reasonable cause to identify good practice from the case to improve partnership working?
Yes
No
Consider Learning Approach or Peer Review Approach
No SAR required. Return to referrer to consider internal review if they wish

Appendix 6 Safeguarding Adult Review (SAR) Request Form

For further information on the Dorset, Bournemouth, Christchurch and Poole Safeguarding Adult Review Policy please see https://www.bcpsafeguardingadultsboard.com/learning--development.html#sarpolicy

Please provide the details requested below to enable members of the SAR Subgroup to make a proportionate decision as to whether this case meets the SAR criteria as set out in the Care Act 2014.

Person requesting Safeguarding Adult Review

Name:	
Job Title:	
Organisation:	
Workplace/Address:	
Contact No:	
E-mail:	

Other named contact if applicable:

Name:	
Job Title:	
Contact No:	
E-mail:	

Person involved in incident:

Name:	
Date of birth:	
Date of death (if applicable):	
Address:	
Ethnic origin:	
GP if known	
Health and/ or other presenting needs:	
Family/ next of kin/ advocate/ representative	

Details of SAR request:

Brief outline of the case/ incident (with dates and locations if known)

Summary of why this case meets the criteria for a SAR				
Please establish the link between cause of death/ harm and the (suspected) abuse/ neglect. Please include views of the adult/ family/ carer where known.				
Do you believe a statutory SAR is required in response to this case?	**Yes**		**No**	

What learning do you think can be achieved through a review of this case?

Has any other learning/ review process already been followed (e.g. internally)?	**Yes**		**No**	
If yes, please specify the review conducted, learning identified, how it was disseminated and impact. Also specify if the process has yet to commence.				

List of individuals and their agencies/ service providers known to be involved in the case
• • • • • • •

Any other relevant information that will help the SAR Subgroup decide whether an SAR is required

When complete please send to The Chair of the Dorset, Bournemouth, Christchurch & Poole Safeguarding Adults Board

For Dorset please send to:
Business Manager, Dorset Safeguarding Adults Board
by email to Karen.Maher@dorsetcouncil.gov.uk
or by post c/o Dorset Council, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

For Bournemouth, Christchurch & Poole please send to:
Business Manager, Bournemouth, Christchurch & Poole Safeguarding Adults Board
by email to Claire.Hughes@bcpcouncil.gov.uk
or by post c/o Adult Social Care – Services, Room 1, Civic Centre, Poole, Dorset BH15 2RU

Name:

Signed:

Print

Date:

Appendix 7 Safeguarding Adult Review (SAR) Individual Management Report (IMR)

SAFEGUARDING ADULT REVIEW

INDIVIDUAL MANAGEMENT REVIEW

COMPLETED BY

NAME OF AGENCY

XXXX
D.O.B: XXXXXXXX

Time period for the SAR: xxxxxxxxxxxxx
Please provide any further significant information prior to xxxxxxxxxx

Details of person completing the IMR and Chronology:	
Name:	
Contact Details:	Email: Telephone number:
Post held:	

Date of request for IMR	
Date of completion of IMR	

INDIVIDUAL MANAGEMENT REPORTS

1. INTRODUCTION

1.1 This document is intended to provide an individual management review of the decisions, actions taken and services provided to XXXXXXX who is subject of a Safeguarding Adults Review instigated by the Dorset Safeguarding Adults Board or the Bournemouth, Christchurch & Poole Safeguarding Adults Board. The Safeguarding Adult Review Panel requested an IMR for return by the XXXXXX

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

1.3 The individual management review provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the adult with care and support needs.

1.4 The IMR author should be able to:

- gather and analyse information,
- clearly describe what happened, commenting on the quality of practice
- provide explanations for why it happened
- clearly show how the conclusions relate to the individual case as well as the wider safeguarding practice within the organisation.

2. METHODOLOGY

List the sources of information that your agency has used to compile your report. This might include paper records, IT systems searched, computer records, supervision notes etc. It should also include some details about staff that have been interviewed as part of this review, or if not why not. Please say if files could not be found and why.

3. FACTUAL/CONTEXTUAL SUMMARY

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

4. CHRONOLOGY OF AGENCY INVOLVEMENT

To be completed on the chronology template provided

5. ANALYSIS OF INVOLVEMENT

The report author is expected to rigorously analyse the involvement of their agency, consider the events that occurred, the decisions made and the actions taken or not. See Guidance for the Completion of IMRs.

6. CRITICAL ANALYSIS

In this section the IMR author must answer the questions below which are taken directly from the Terms of Reference. Take time to reflect on the information you have provided in the chronology. The information provided and the analysis should be appropriately evidenced/explained fully.

Please ensure to clearly specify if any of the questions are not relevant to your agency and/or service and the reasons why. If a question is left blank it could be queried by the SAR Author.

6.1 Learning for all agencies around assessing risk

6.2 Roles and responsibilities, opportunities for proactive joint working.

6.3 Managing high risk cases in the community – multi agency support/protection plans and contingency plans.

6.4 Mental Health and Self Neglect – approaches to long term planning.

6.5 To consider looking at structures and processes.

7. WHAT DO WE LEARN FROM THIS CASE?

Following on from the critical analysis section previously, the IMR author should identify specific lessons which his/her agency can learn from the case. These can include areas of good or poor practice identified, as well as ways in which practice can be improved.

8. RECOMMENDATIONS FOR ACTION

Any recommendation about improving or developing new procedures should be specified in terms of the expected practice outcomes. Actions contained in this IMR report will be considered by the SAR Panel for inclusion in the SAR Report. The SAR Panel may also recommend further actions for your agency to be included in the SAR Report. You should add as many actions for your agency as is necessary.

Glossary of Personnel involved

Name	Job Role	Identification in report

IMR – Chronology of Involvement

Please complete with the information required under each heading. The last column should be used for comments on the appropriateness/quality of the intervention or whether it raises any other professional issue.

Date	Source of Evidence	Name of Professional involved and role	Type of Intervention	Action taken/decision made	Comment

IMR - Guidance for the Completion of Individual Management Reports [IMR]

ANALYSIS OF INVOLVEMENT

The Terms of Reference should be referred to as headings to analyse practice against and facts should not be stated without their origin. Consider specifically the following questions:

- Were practitioners aware of and sensitive to the needs of the adult in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about an adult with care and support needs' welfare?

- When, and in what way, were the adult's wishes and feelings ascertained and taken account of when making decisions about the provision of the adult's services? Was this information recorded?

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of adults with care and support needs and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult and their family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

- Where relevant, were appropriate Safeguarding Adult's or care plans in place, and the reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the adult and their family, and were they explored and recorded?

- Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Was the work in this case consistent with each organisation's and the policy and procedures for safeguarding and promoting the welfare of adults with care and support needs and with wider professional standards?

- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations?

- Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

Appendix 8 Safeguarding Adult Review (SAR) Summary Report

SAFEGUARDING ADULT REVIEW
Summary Report

CASE

D.O.B:

Time period for the SAR: xxxxxxxxxxxxxxxxxxxx

Details of person completing the Summary Report:	
Name:	
Contact Details:	Email: Telephone number:
Post held:	

Date of request for Report	
Date of completion of Report	

We have asked for a short report because we understand from the information we have received that your agency had limited engagement with this case or the contact you had was outside of the agreed timescale set for this SAR.

The short report should reflect the lines of enquiry and issues in relation to equality and diversity as identified in the Terms of Reference.

Brief factual/contextual background information about your agency / service offer at the time	
Summary of agency involvement - how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken	
Consider whether different decisions or actions may have led to a different course of events. Highlight any examples of good practice	

Regardless of contact, analyse agency capacity to manage the following issues arising from this case – ***Please answer in reference to the key lines of enquiry included in the Terms of Reference***	
Summarise changes to agency / pathway since the time period under review	
Any recommendations where appropriate	