SUNDERLAND SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW PROTOCOL

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Contents

1. INTRODUCTION

1.1 The purpose of this protocol is:

- To support the view that the public interest is best served by the presence of an effective and robust Adult Review process in relation to safeguarding adults.
- To provide guidance to Sunderland's Safeguarding Adults Board (SSAB) in establishing and managing Safeguarding Adult Reviews (SARs).
- To facilitate a consistent approach to the process and practice in undertaking a SAR.
- To provide guidance in circumstances where the criteria for a SAR have not been met, in accordance with the SSAB Learning and Improvement in Practice (LIIP) Framework.

1.2 The document *Safeguarding Adults* published by the Association of Directors of Social Services (ADSS) (October 2005) provides a National Framework of Standards of Good Practice and Outcomes in adult protection work, and recommends that:

"There is a 'Safeguarding Adults' Serious Case Review[1] Protocol. This is agreed on a multi-agency basis and endorsed by the Coroner's Office and details the circumstances in which a Serious Case Review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a Domestic Homicide Review should be clear".

And:

"There is a clear process for commissioning and carrying out of a Serious Case Review by the Partnership".

- Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work (ADSS, 2005)

1.3 The SCIE Safeguarding Adult Review Quality Markers are a tool to support people involved in commissioning, conducting and quality assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs. The Quality Markers are based predominantly on established principles of effective reviews / investigation as well as experience, expertise, and ethical considerations and have been used as a benchmark to ensure this protocol reflects best practice.

[1] Following the implementation of the Care Act (2014) the term 'Safeguarding Adult Review' replaced the term 'Serious Case Review'.

2. Purpose of a Safeguarding Adults Review

2.1 The Care Act (2014) includes a requirement for Local Authorities to hold Safeguarding Adult Reviews (SAR) in certain circumstances and for partners on the Safeguarding Adults Board to co-operate in the process.

2.2 The Care Act (2014) also highlights six key principles that underpin all adult safeguarding work, and which should be used to inform professional practice and assist Safeguarding Adults Boards to improve their local arrangements:

- **Empowerment –** People being supported and encouraged to make their own decisions and informed consent.
- **Prevention –** It is better to take action before harm occurs.
- **Proportionality –** The least intrusive response appropriate to the risk presented.
- **Protection –** Support and representation for those in greatest need.
- **Partnership –** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability –** Accountability and transparency in delivering safeguarding.

2.3 The purpose of having a SAR is not to reinvestigate or to apportion blame; any evidence of professional negligence would be dealt with through appropriate routes such as disciplinary procedures in the relevant agency.

A SAR is not an enquiry into how an Adult at Risk has died or who is culpable; that is a matter for coroners and criminal courts respectively to determine as appropriate. Rather it is:

2.4 To identify any lessons that can be learned from the case:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of policy and procedures (both multi-agency and those of individual organisations);
- To inform and improve local multi-agency practice;
- To improve practice by acting on learning (developing best practice);
- To prepare and commission an Overview Report (depending upon the methodology chosen to support the review process) which brings together and analyses the findings of the various Single-Agency Reports from agencies in order to make recommendations for future action.

2.5 The focus of a SAR should be upon the way in which local professionals and agencies work together to safeguard and promote the welfare of vulnerable

adults. The focus will be on the outcome of the process; the recommendations/actions and the monitoring and reviewing of the recommendations/actions. It will ensure that all appropriate actions have been taken with a view to learning lessons for the future both locally and nationally. It will also focus on how the learning is shared with appropriate partner agencies.

2.6 It is acknowledged that individual agencies may have their own internal/statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice. In order to conform to the objectives set for the Safeguarding Adults Board, there is an expectation that member agencies will support the SAR process as set out in this Protocol and/or other review processes which are initiated within the Learning and Improvement in Practice Framework. Also, that agencies will have in-house systems in place, which will identify cases which will meet the criteria for Adult Review.

2.7 SARs are not part of any disciplinary process but information that emerges in the course of a Review may indicate that disciplinary action should be taken under established procedures in the agency concerned. Alternatively, disciplinary action may be conducted concurrently, and in some situations, disciplinary action may need to be taken urgently to safeguard others. This will be a matter for the individual agency concerned.

2.8 The following principles should be applied by SABs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed (as soon as any potential conflicts of interest are identified, or become apparent these should be declared and managed in accordance with the requirements of this protocol);
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- In support of the values of Making Safeguarding Personal (Making Safeguarding Personal: Guide 2014. ADASS, 2014) consideration should

be given to involvement and information sharing with individuals who are the subject of a review. This should include consideration in relation to:

- The individual's capacity to contribute/be involved;
- Any special measures or reasonable adjustment that can be made to involve the individual or their family;
- What information can be appropriately shared;
- Timeliness of information sharing;
- The potential impact on the individual being aware of and involved in the SAR process;
- The nature and extent of their involvement;
- Who would be best placed to lead on the consultation with the individual.

- Where individuals and/or their families are involved in a review, whilst their involvement cannot be as a key decision-making role they should be invited to contribute to reviews and their views should be used positively and appropriately to inform the management of the SAR. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- If the individual's family member(s) is/are a suspected or confirmed perpetrator of abuse and/or neglect, then very careful consideration would need to be given as to whether to involve them in the review or not. Benefits may involve wider learning that could be applied to other cases, e.g. identification of coercion and control indicators or abuse patterns from perpetrator behaviour, that could be shared with frontline staff to help them identify abuse/neglect in cases they are involved in. Reasons not to involve the perpetrator(s) could include that no learning would be gained from involving them, or that to involve them would cause a greater risk to the individual who is the subject of the review.

2.9 If an adult has no appropriate person to support them and has substantial difficulty in being involved in the review process, they must be informed of and or supported to exercise their right to an independent advocate.

3. CRITERIA FOR A SAFEGUARDING ADULT REVIEW

3.1 In accordance with Section 44 of the Care Act (2014), a Safeguarding Adults Board (SAB) must arrange a SAR of a case involving an adult in its area with needs for care and support (whether or not the local authority is meeting those needs) if:

- There is concern that partner agencies could have worked together more effectively to protect the adult, **and**;

- The 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:**
- The adult is alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect[2].

3.2 In the context of SARs, 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. In such cases, section 42 enquiries into what happened to the person may still need to take place in parallel, to ensure the person's immediate safety and the safety of any others who may be at risk but should be limited to those purposes rather than duplicating more thorough investigations into the history which may take place through a SAR.

3.3 Section 42 enquiries are those undertaken when an adult at risk has been identified as having experienced or being at risk of abuse and/or neglect. A section 42 enquiry cannot be undertaken in relation to a person who is deceased. Instead, consideration should be given as to whether the SAR criteria are met under section 44 of the Care Act (2014).

3.4 Each member of the SAB must co-operate in and contribute to the carrying out of a review under section 44 with a view to -

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

(b) Applying those lessons to future cases.

3.5 In circumstances where the above criteria have not been fully met, SABs are free to arrange for another type of review, including in cases of good practice, where it is likely that lessons can be applied to future cases. This is a decision for the LIIP Sub-Committee.

4. INTERFACE WITH OTHER (STATUTORY) REVIEWS

4.1 Some external statutory reviews led by other agencies may involve an adult at risk[3], or may concern an adult safeguarding case that is the subject of a SAR, such as a Child Safeguarding Practice Review (SPR) r or a Domestic Homicide Review. In setting up a SAR the SAB should also consider how the process

[2] Also included within the definitions of abuse and neglect are self-neglect and self-abuse

[3] Defined in the Care Act (2014) as someone who has needs for care and support (whether or not the local authority is meeting these needs), who is experiencing, or at risk of, abuse and neglect, and as a result of their care needs is unable to protect themselves

can dovetail with any other relevant reviews or investigations that are running parallel, including a criminal investigation or an inquest.

4.2 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a Child Safeguarding Practice Review (SPR) and a Domestic Homicide Review (DHR).

4.3 When running a SAR and DHR or child SPR, all relevant areas that need to be addressed should be established at the outset 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 Independent Chair of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

4.4 Where such reviews may be relevant to a SAR (e.g. because they concern the same perpetrator), consideration should be given as to the most appropriate and effective review methodology to achieve joint outcomes, enabling organisations and professionals to learn from the case, and avoid duplications of process, this may include:

- a jointly commissioned review, or
- parallel reviews, or
- a single review commissioned by only one agency – with a decision made as to who will be the lead agency for this.

4.5 Where the other review process is a non-statutory arrangement such as LeDeR, a statutory review will ordinarily take precedence; in practice this may involve ceasing the non-statutory process and commissioning the - SAR. In these circumstances to reduce potential for duplication for families and staff the LIIP Sub-Committee/SAR Panel should consider work that has been completed in the non-statutory review and whether:

- information from the non-statutory review should be incorporated into the SAR
- whether the non-statutory review is so advanced that the panel consider adding additional information/components to this to form a SAR
- Whether a new SAR process should be initiated alongside the non-statutory review.

4.6 Other types of processes and investigations which may also need to be taken account of when conducting or considering conducting a SAR could include (list not exhaustive):

- Serious Incident investigations (SIs)

- Mental Health Homicide Reviews
- Disciplinary proceedings
- Judicial reviews
- Complaints
- Criminal Justice processes
- Coroner's Inquests
- IOPC (Independent Office for Police Conduct) investigation

4.7 Information generated or obtained in the SAR whilst a criminal case is ongoing will be made available to the Senior Investigating Officer (SIO) to determine whether it is relevant to the criminal case. Where it is relevant, it will be for the Crown Prosecution Service (CPS) to decide whether it should be disclosed to the defence. Where the material is sensitive, the CPS or the SIO will consult with the SAR Chair before disclosure is made to the defence. If the SIO confirms that the criminal investigation would not be compromised then the Overview Report can be used in its draft form (until after the criminal trial) and actions can be taken to ensure organisational learning needs are addressed, as long as this does not compromise the criminal investigation. Following conclusion of the criminal proceedings, the SAR should be concluded without delay.

5. REQUESTING A SAFEGUARDING ADULT REVIEW

5.1 The Safeguarding Adults Board will be the only body able to commission a SAR.

5.2 Any agency, professional or individual may refer a case believed to fit the criteria for a SAR as outlined in Section 3. The referral should be discussed with your agency's safeguarding lead before being submitted on the SSAB's SAR Referral Form, a copy of which is shown in appendix 1.

5.3 Once an agency has identified that a SAR may be required, the referral must be made immediately. It is essential that the referrer sets out clearly a summary of the incident /concern which details key areas including the nature of the abuse, whether known or suspected, and the details of the concern that partner agencies could have worked more effectively to protect the adult.

5.4 When completing the reason for referral section the referrer should set out their rationale as to why they believe the case may meet the criteria for a SAR. This will ensure that the SSAB consideration of the case specifically addresses the areas of concern identified by the referring agency and will support effective decision making by the LIIP Sub-Committee on behalf of SSAB.

5.5 Information shared by the Coroner may be considered for a SAR or, where the criteria are not met, another form of review in accordance with the Learning and Improvement in Practice Framework. Where the Coroner's information has been considered the Chair of SSAB will advise the Coroner in writing detailing the outcome and decision.

5.6 Where the LIIP Sub-Committee has examined a case that has been referred for consideration as a SAR the Chair of the LIIP Sub-Committee, will provide a written recommendation to the SSAB Independent Chair setting out the background to the case and the decision/recommendation reached by the Sub-Committee. The written recommendation will also include the rationale for the decision and any key considerations which influenced the decision.

5.7 Following confirmation from the SSAB Independent Chair as to whether the LIIP Sub-Committee recommendation has been accepted, the Chair of the LIIP Sub-Committee will, on behalf of the SSAB, provide written confirmation of the decision to the referrer. Where the SAR criteria has not been met, the referrer will be provided with the rationale and decision making in relation to any further non-statutory review/consideration.

5.8 Should the referrer disagree with the recommendation made by the LIIP Sub-Committee, this should be raised in writing with the Chair of the sub-committee in the first instance. This will be escalated to SSAB via the Independent Chair. If disagreement still exists, the SSAB Executive Group will be asked to review the recommendation and make a majority decision.

5.9 The Strategic Safeguarding Team provide administrative and project management support to both SSAB and the LIIP Sub-Committee in relation to the implementation of the SAR Protocol. On receipt of a SAR referral the Strategic Safeguarding Team will undertake an initial screening of the referral and will advise the Chair of the LIIP Sub-Committee. To ensure an appropriate and timely response the Chair of LIIP Sub-Committee will consider whether a multi-agency scoping exercise can and should be undertaken at the next LIIP Sub-Committee, or whether a separate extraordinary LIIP Sub-Committee scoping meeting needs to be arranged. No other organisation should make the decision.

6. Multi-Agency Scoping Meeting

6.1 Following receipt of a referral and screening by the Strategic Safeguarding Team, the Chair of the LIIP Sub-Committee will be informed of all cases believed to meet the criteria for a SAR. A scoping meeting should ordinarily be undertaken within a 6-week timescale.

6.2 Following agreement from the Chair of the LIIP Sub-Committee the Strategic Safeguarding Team will circulate a scoping report template (see appendix 2), to partner agencies for completion and submission prior to the scoping meeting. The referring agency's referrer and/or their Safeguarding Lead will also be asked to attend the scoping meeting to discuss the reason/rationale for their referral. Agencies will be reminded of Section 45 of the Care Act (2014), which outlines the expectation that organisations share information and be fully compliant in circumstances where information is required to enable the SAB to exercise its functions.

6.3 The Data Protection Act governs the personal data of all living individuals, therefore following the death of a person the data protection principles do not normally apply and the full sharing of information is permissible. If the subject(s) of a SAR are alive then information should be shared in accordance with the Data Protection Act (2018) and General Data Protection Regulations (GDPR) and the SSAB's Information Sharing Agreement.

6.4 At the scoping meeting, attendees will be asked at the start of the meeting to declare any Conflicts of Interest. Where a conflict is identified, this will be recorded along with the actions taken to address the conflict. The person with the conflict of interest will only be able to participate in the meeting at the discretion of the Chair.

6.5 Members of the LIIP Sub-Committee will be invited to attend the scoping meeting, regardless as to whether their agency has had involvement with the subject and will be involved in considering the information presented at the meeting and in the decision as to whether the SAR criteria has been met.

6.6 The Chair of the LIIP Sub-Committee will aim to gain a unanimous decision from the partners represented at the meeting as to whether the criteria have been met; if this cannot be reached a majority decision will be accepted. Where there is a majority decision this shall be recorded in the minutes and detail those members/organisations who did not agree with the majority.

6.7 Where the recommendation is that the criteria to conduct a SAR have not been met, the meeting members will consider whether an alternative means of review should be initiated, in accordance with the LIIP Framework.

6.8 The SSAB Independent Chair is ultimately accountable/responsible for the decision whether a case meets the criteria for a SAR, on the recommendation of the Learning and Improvement in Practice (LIIP) Sub-Committee. Within 5 working days of the scoping meeting the Chair of the LIIP Sub-Committee will inform the SSAB Independent Chair in writing, detailing the background of the case, any key discussion and the decision made, including whether the decision has been unanimous, or a majority. In cases where it is a majority

decision the recommendation will detail the level of majority and the key issues of dissent.

6.9 The SSAB Independent Chair will decide whether to accept the decision of the scoping meeting panel. Where they confirm a decision to commission a SAR, they will immediately inform:

(a) The Care Quality Commission (CQC) of any relevant case, where they have regulatory oversight, that becomes the subject of a Safeguarding Adult Review
(b) The Safeguarding Adults Board of the decision, brief circumstances and scope of the review

7. INITIATING A SAFEGUARDING ADULT REVIEW

7.1 If the recommendation to undertake a SAR is agreed, a multi-agency Safeguarding Adult Review Panel will be set up within one month of the SSAB Independent Chair having been informed of the outcome of the scoping meeting, with membership comprised of appropriate representatives of the agencies involved. The Panel will take account of the SAR Quality Markers throughout the review process.

7.2 The Chair of SSAB will write to the Chief Officers of all the agencies involved for nominations to the SAR panel and will request that records relating to the subject(s) of the SAR are made secure to prevent any adaptation.

7.3 The SAR Panel will have delegated responsibility for managing the SAR, including the appointment of the Independent Chair for the panel, identifying and commissioning a reviewer (Independent Author), agreeing the Terms of Reference and methodology/model for the review, and providing quality assurance and challenge throughout the review process.

7.4 The Strategic Safeguarding Team will provide administrative support as well as project management support, guidance in relation to Sunderland Safeguarding Adults policies and procedures and will be responsible for liaising with the SAR Independent Chair.

7.5 At the earliest opportunity the SAR Independent Chair will be responsible for consulting with, and/or involvement of the subject (if living) and/or their family. Key considerations are set out above in section 2.9. Where there is a decision to consult /involve the subject/family the SAR Independent Chair will maintain oversight of these arrangements.

7.6 Anonymisations and pseudonyms should be agreed as soon as possible in the review process. A name rather than initials, letters and/or numbers should be

used as this humanises the subject of the review and allows the reader of the Overview Report to more easily follow the narrative.

7.7 The SAR Independent Chair will ultimately be responsible for establishing individual terms of reference but should take into account any appropriate views expressed by the subject and/or their family and should also consult the SAR panel to ensure the terms of reference are sufficiently comprehensive. The SAR Independent Chair will also be responsible for setting the outline timescales for the SAR in agreement with the Safeguarding Adults Board. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted in accordance with the terms of reference. Where there is any subsequent need to revise timescales for the SAR the Independent Chair will ensure that the SSAB are advised and updated.

7.8 Where appropriate, the SAR Independent Chair will liaise with the Coroner's Office and/or Police to ensure that arrangements for undertaking a SAR are acceptable and do not conflict with any other investigative processes being undertaken.

7.9 Nominated leads from all agencies involved will be notified and will be responsible for notifying staff members who have been involved in the case. Agencies are responsible for providing staff with emotional support where necessary and dependent upon the nature of the SAR. It is also important that all staff are made aware that the purpose of a SAR is not to apportion blame, but rather to learn lessons in order to improve future practice.

7.10 It is acknowledged that resources are required for undertaking and supporting a SAR. It is the responsibility of the Safeguarding Adults Board to ensure adequate resources and funding are in place in order for the SAR process to work effectively, to ensure an Independent Chair can be commissioned for each SAR and that the Chair and panel members receive adequate administrative support and will take a decision on how and from whom this will be provided.

8. CONDUCTING A SAFEGUARDING ADULT REVIEW

8.1 In accordance with the Care Act (2014) guidance, the SAR should be completed within 6 months of the original decision to proceed, unless there are particular circumstances which mean an alternative timescale has had to be agreed at the outset as part of the initial SAR panel meeting.

This initial meeting will agree:

- Terms of reference
- Methodology to be used for the review

- ‘Evidence’ required from each agency/participant
- The role the adult at risk and/or family will have in the SAR
- The need for Advocacy Services
- Support and other resources needed (any perceived deficits to be referred to the Chair of the Safeguarding Adults Board)
- Timescales within which the SAR process should be completed – the SAR should be completed within six months of initiating it unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings
- Dates, times and venues of meetings
- Media strategy
- Identification and dissemination of learning
- The nature and extent of legal advice required, in particular Data Protection, Freedom of Information and the Human Rights Act.
- Procurement of a Safeguarding Adult Review Independent Author

8.2 Consideration and due regard to family members, carers and the individual (where relevant) must be observed as all times in the SAR process, with consideration given to the involvement of an Independent Mental Capacity Advocate. See also points 2.9 and 2.10 above.

8.3 The panel should establish a suitable professional who can act as a single point of contact to the family members, carers and individual (where relevant) with regard to their involvement in the SAR process.

8.4 The Chair of the SAR Panel will convene a publication impact meeting ensuring that relevant communication leads, the Independent Author and Chair of the SSAB are invited. Legal Services may also be invited where appropriate.

8.6 Media interest will be co-ordinated through the Chair of SSAB and press statements will be co-ordinated through the Local Authority’s Press Department on behalf of the Board, which would have the agreement of the Local Authority’s Chief Executive.

8.7 Freedom of Information requests, in respect of request for information from SARs will be dealt with by the Local Authority through the Chair of SSAB to ensure consistent and relevant information sharing.

8.8 Depending upon the SAR methodology, agencies may be required to produce an Individual Management Report (IMR) outlining any and all information provided to the SAR from that agency. Personnel compiling the report should have the appropriate skills, knowledge and training to produce the report.

8.9 IMR reports should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;

- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

8.10 In circumstances where agencies are not required to provide IMRs, for example when using a systems methodology, agency leads are expected to support the Independent Author in understanding the broader agency perspective, procedures and systems within their organisation.

8.11 Where an out of area agency is required to submit an IMR contact will be made by the SAR Chair. The agency will be asked to nominate an IMR author as well as a senior officer who will sign off the report and sit on the SAR Panel. The nominated person will be included in all circulated emails of the SAR and kept informed of the process. Out of area agencies will be expected to use the SSAB IMR template. Out of area agencies are, wherever possible expected to attend IMR briefings and SAR Panel meetings.

8.12 In cases of lack of engagement from an agency in the SAR process, which can be detrimental to all agencies involved and the progress of the review, the following stages should be followed:

- The Panel member or IMR author should contact the SAR Chair to discuss any concerns they may have or difficulties with meeting deadlines, and agree a mutually acceptable outcome
- If the Panel member/IMR author is unable/unwilling to resolve the issue, the SAR Chair should contact the nominated senior manager that will sign-off the work completed by the IMR author and discuss issues with them
- If none of the above are possible it may be necessary to escalate the issue to the SSAB Independent Chair

8.13 The SAR Independent Author will produce an independent Overview Report, which collates the information, analyses it and makes recommendations. The recommendations must be SMART (Specific, Measurable Achievable/Attributable, Realistic and Time-specific). Where IMRs are produced (dependent upon the review methodology used) these will be made available to the SAR Independent Author. The Independent Chair will ensure that the Overview Report is written and delivered within agreed timescales to an agreed format.

8.14 The draft report will be presented to the Review Panel for comment and approval before being presented to the full Board for sign-off. Upon receipt of the report the Board will:

- Clarify to whom the report, or any part of it, should be made available, including the Care Quality Commission and the means by which this will be done;
- Disseminate report of key findings to interested parties as agreed;
- Agree arrangements to feedback to staff, family members or media as appropriate

8.15 The report will contain an Executive Summary which, subject to legal confirmation, will be made public on the Sunderland Safeguarding Adults Board website and via Partner Agency websites. The Publication arrangements for each SAR will be agreed by the SSAB as part of the Board's sign off arrangements. Key considerations should include:

- Date for the publication
- Impact on the subject and/or their family
- Arrangements to advise/inform the subject/family in advance of the publication.
- Coordination and briefings across the partnership
- Media planning

8.16 The Safeguarding Adults Board and Independent Chair of the SAR should always come to a decision as to whether the report is anonymised/redacted in order to protect the interests of the adult at risk and/or their family.

8.17 If at any stage whilst undertaking the SAR process information is received which requires notification to a statutory body, e.g. Health and Care Professions Council (HCPC) or Disclosure and Barring Service's Barred List, regarding significant omission by individual(s) or organisations this should be done without delay by the employing organisation in accordance with the HR policy and processes.

8.18 Safeguarding adults practice or procedural changes may be identified as being necessary at any point in the Review process and may be made immediately in order to safeguard others.

8.19 The Overview Report will first be approved by the SAR Panel. It is anticipated that the report will have followed a process of amendment over more than one meeting, depending on the complexity of the case. Throughout this process the SAR Panel members will be required to update their relevant senior manager regarding any changes that impact on their agency.

8.20 The SAR Panel need to scrutinise the Overview Report to:

- Ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the report
- Be satisfied that the report accurately reflects the panel's findings

- Ensure that the report has been written in accordance with the SSAB SAR Protocol
- Ensure that the report demonstrates sufficient probing, analysis and a balanced narrative
- Be satisfied that lessons to be learnt have been identified, any recommendations/actions are SMART (specific, measurable, achievable, realistic, and timely), and plans are in place to ensure this happens

8.21 Upon conclusion of the SAR process, a debrief should be held with the SAR Panel to consider what went well, what could have been done differently and whether the SAR Protocol should be reviewed in order to address any issues raised.

8.22 Records relating to a SAR will be stored securely by the Strategic Safeguarding Team for a period of six years following the publication of the SAR or the 25th anniversary of the subject's birth[4] (whichever is later). At this point, the files relating to the SAR would be reviewed before destruction to determine whether further retention was required, such as information becoming more significant in the light of later events or the likelihood of future legal proceedings by anyone involved. The decision to destroy or further retain records relating to a SAR will be approved by the LIIP Sub-Committee (and supported by legal advice). If the decision is to proceed with destruction, all agencies who may be retaining duplicate records will be notified in order for them to consider whether to delete or amend their own records.

9. ACTING ON THE RECOMMENDATIONS OF THE SAFEGUARDING ADULT REVIEW

9.1 All actions and recommendations resulting from the SAR process will be incorporated into an action plan.

9.2 The SAR panel will take the lead in ensuring the action plan is developed.

9.3 The action plan will indicate:

- Responsibilities for various actions
- Timescales for the completion of agreed actions
- The intended outcome of the various actions and recommendations

[4] Under the Limitation Act 1980, there is generally a statutory limitation period of 6 years in which civil claims may be instituted. This time period does not start to run until age 18. The suggested retention periods are in accordance with this limitation period

- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems.

9.4 SSAB, via the LIIP Sub-Committee, will be responsible for ensuring the monitoring and implementation of the Action Plan. It will ensure that all recommendations are actioned and will request updates from the relevant agencies. The Action Plan will remain on the agenda until such a time that all actions have been completed.

9.5 The Action Plan will be shared with the Quality Assurance Sub-Committee at an appropriate stage (depending on the nature of the actions identified) to consider if any themed audit and/or assurance work is required.

10. FINDINGS FROM SAFEGUARDING ADULT REVIEWS

10.1 The SAR Panel will be responsible for identifying 'Lessons Learnt' from Reviews to be shared across the multi-agency partnership, focussing on key messages for practitioners and front-line staff. This may take the form of multi- or single-agency briefing sessions, briefing notes and updates to multi-agency safeguarding training provided by SSAB, via formal communication links with the training provider.

10.2 The findings from any SAR will be included in SSAB's Annual Report and will include what actions it has taken or intends to take in relation to those findings. Where SSAB decides not to implement an action then it must state the reason for that decision in the Annual Report.

10.3 Any findings from a SAR that require a national response will be escalated using the nationally agreed escalation protocol.

10. 4 All documentation SSAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

10.5 All SAR reports should be submitted to the regional and national SAR Libraries within a suitable timeframe once published. The SAR report should be appropriately coded to allow it to be used effectively within the library.

RESTRICTED when Completed

Referral for case to be considered for Safeguarding Adult Review (SAR)

Please complete the form below as fully as possible and return by email to: strategic.safeguarding@sunderland.gov.uk

Date of referral	
Referrer Details (including name, role, full contact details and secure email)	

Details of Adult at Risk	
Full name	
Also known as	
Gender	
Ethnic Origin	
Date of Birth	
Date of Death (If applicable)	
Home address (including postcode)	
Language spoken (please include whether an interpreter is required)	

Summary of incident/concern	
Reason for referral	

Family Details			
Name	DoB/Age	Relationship to Adult at risk	Home Address

Services Involved with the adult at risk			
Name	Designation/Role	Agency	Contact Details

To be completed by Strategic Safeguarding Team on receipt of referral:

SSAB Action Taken	
Date Received:	Date SSAB Chair Notified:
Scoping Meeting Date:	Decision of SSAB Chair

Appendix 2

RESTRICTED when completed

SSAB LEARNING AND IMPROVEMENT IN PRACTICE SUB-COMMITTEE REPORT FOR AN INITIAL SCOPING MEETING IN RESPECT OF 'insert name'

1.	Name and Designation of Report Author:	
	Date of Meeting:	
	Meeting where report is to be considered:	
	Date report due:	
	Report to be returned to:	

2.	Reason for Report
	To give consideration under the SSAB LIIP Framework as to whether this case meets the criteria for a Safeguarding Adult Review, or any other learning review. **Information specific to the individual and circumstances leading to the referral for consider of a SAR to be added here.**

3.	Subject of the report			
	Name	D.O.B	Date of Death (DoD)	Address

4.	Other family members (please add to if you have additional information that supports this scoping exercise)		
	Name	D.O.B	Address

5.	Professionals known by your agency to be involved with the adult		
	Name/Professional Group	Designation/Agency	Contact Details

6.	Case synopsis (this should include a case history, and **significant events** leading up to the concerns being identified. Please include date case opened/closed (if appropriate) and any work undertaken directly with the adult or any family member your agency is involved with

7.	Any other information