Safeguarding Adults Review Procedure

Essex Safeguarding Adults Board

Version:	Version 2
Review & edit	Deborah Stuart-Angus
Authors	Caroline Venables, Safeguarding Adult Review Officer, ESAB Paul Bedwell Board Manager, ESAB
Ratified by:	Safeguarding Adult Review Committee
Date ratified:	23 September 2021
Approved by:	Essex Safeguarding Adults Board
Date approved:	19 January 2022
Date issued:	24 January 2022
Review date:	January 2023
Target audience:	Partner agencies and professionals

Contents

Safeguarding Adults Review (SAR) Procedure

The deployment of this procedure will:

- provide a framework for ESAB and its partners to conduct a SAR in accordance the Care Act 2014 and its associated statutory guidance.
- ensure governance is in place for the achievement of complex and challenging task.
- assist professionals to decide when to refer a case for consideration as a SAR.
- recognise other forms of statutory reviews (e.g., Domestic Homicide Reviews (DHRs), Mental Health Homicide Reviews (MHHRs) and Multi Agency Public Protection Arrangement (MAPPA) Reviews) and acknowledge the importance of managing the interface.
- ensure that the adult; their family or their representative(s) must be offered the opportunity to contribute to the SAR process and the necessary support to do so, which may include an advocate.
- ensure that lawful compliance has been maintained and promoted.

Introduction

The Care Act 2014 places a statutory duty on Safeguarding Adults Boards to undertake Safeguarding Adult Reviews (SARs)[1]. Safeguarding Adult Reviews are comprehensive, complex, and detailed and undertaken solely for the purpose of learning from individual cases, where agencies could have worked better together, with the aim to continuously improve the effectiveness of practice for safeguarding adults at risk. Essex Safeguarding Adults Board (ESAB) is responsible for hosting Safeguarding Adults Reviews, and it is committed to demonstrating effective learning and improvement in practice, following serious, or significant multi-agency incidents.

SARs should reflect the six principles of adult safeguarding outlined in the Care Act 2014:

- Empowerment
- Prevention
- Protection
- Proportionality
- Partnership
- Accountability

This procedure has been developed by ESAB and should be considered in conjunction with the Southend, Essex, and Thurrock (SET) Safeguarding Adults Guidelines.[2] Members of the Safeguarding Adults Board are required to co-operate and contribute to SARs by sharing information and applying lessons learnt, within their organisations. The Care Act 2014 (s45)[3] also enables the Safeguarding Adults Board (SABs)to request relevant information from anyone, in order to support the SAB in undertaking a SAR. Each SAR should take into account what was known to practitioners working with the individual or could have reasonably been expected to have been known, by them, at the time. Consideration should also be given to the mental capacity of the person at risk and their views and choices.

Purpose of a Safeguarding Adult Review

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[2] https://www.essexsab.org.uk/media/2498/set-safeguarding-adult-guidelines-final.pdf

[3] https://www.legislation.gov.uk/ukpga/2014/23/section/45/enacted

- establish if there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies worked together to safeguard the adult at risk
- review the effectiveness of procedures
- inform and improve local inter-agency practice
- improve practice by acting on learning and highlighting good practice.

SARs should determine how relevant agencies may have worked differently together, in order to have prevented harm or death, and to prevent similar from happening again. The SAR should not re-investigate a case, or apportion blame and other processes exist, such as criminal proceedings, regulatory requirements, HM Coroner Inquests, organisational disciplinary procedures, employment law and professional regulation - e.g., Nursing and Midwifery Council; Health and Care Professions Council, and the General Medical Council). This approach supports a culture of continuous learning and improvement across multi-agency working, where the promotion of wellbeing and empowerment holds significance. SARS should encourage honesty and transparency and provide a safe place to share information, to garner trust within the organisations involved and maximise their participation. Effective Chairing of a SAR is vital.

When should a Safeguarding Adults Review (SAR) be undertaken?

A SAR can only be commissioned by the Safeguarding Adults Board. ESAB has a statutory duty to arrange a SAR in the following circumstances:

- the mandatory duty to conduct a SAR (Section 44(1-3) Care Act 2014)

ESAB must arrange a SAR where a case involving an adult at risk, in its area who has care and support needs (whether or not the local authority has been meeting any of those needs) if:

a) There is reasonable cause for concern about how ESAB, its members or organisations worked together to safeguard the adult

and

b) The person died and ESAB knows or suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

or

c) The person is still alive, but ESAB knows or suspects the person has experienced serious abuse/neglect; sustained potentially life-threatening injury; serious sexual abuse or serious/permanent impairment of health or development.

The Care Act Statutory Guidance outlines that in the context of SARs something can be considered as 'serious abuse or neglect' for example:

• the individual would have been likely to have died but for an intervention
• the individual has suffered permanent harm
• the individual has reduced capacity or quality of life (whether because of physical or psychological effects)
• the individual has suffered serious sexual abuse.

- The discretionary duty to conduct a SAR (Section 44(4)) Care Act 2014

ESAB may also arrange for a SAR in any other situation which involves an adult, in its area, with care and support needs, (whether or not the local authority has been meeting any of those needs). This may involve be cases which provide useful insights into the way organisations work together to prevent and reduce abuse and neglect of adults at risk, which may not meet the mandatory criteria for conducting a SAR.

In all cases, the adult must have care and support needs, but they do not have to have been in receipt of care and support services for ESAB to arrange a SAR. In relation to discretionary decision making, the following should be considered

- Was the adult abused/neglected in an institutional setting?
- Was the adult abused/neglected while being supported by the local authority or an NHS Trust?
- Does one or more agency, or professional, consider that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?
- Are there concerns that the policy or practice of one or more agencies may have hindered other agencies' ability to protect the adult, such as information sharing or resources?
- Is there concern that an emerging theme may lead to serious harm or death of an adult, if not tackled, such as under reporting of particular types of abuse or lack of advocacy?
- Does the case suggest that ESAB may need to change its local policy, protocols, or practice guidance, or that the former was not adequately disseminated, understood, or acted upon?

A positive response to most of these questions, is likely to indicate that a Discretionary SAR should be carried out. SARs may also be used to explore examples of good practice, if such an exercise will benefit other cases.

Identification and referral of cases for a SAR

It is the responsibility of those who work with adults with care and support needs to make a SAR referral, where there are reasonable grounds to consider that the SAR duty, may be met. SAR referrals should be timely, and explanations should be sought, if there are delays in submitting referrals. The referrer must complete the SAR referral form setting out how the duty has been met and focus on potential learning for ESAB and its partners. Professionals who refer must have senior management endorsement of the referral (the form is available from and should be returned to the ESAB Team: esab@essex.gov.uk., there is also a copy at One. If the referrer does not have a secure email address, they must telephone the Safeguarding Adults Board Team (03330 131019) and discuss how best to send the form.

Any of the following can make an application for a review:

- Any organisation that has worked with the adult
- Any organisation represented on the safeguarding adult board
- The adult concerned, their family, advocate, carer, friend
- Any other individual acting on the adult's behalf such as a Coroner, MP, or Elected Member.

The ESAB SAR Officer welcomes discussions regarding the appropriateness of referrals and can be contacted via email at esab@essex.gov.uk. A SAR referral is acknowledged within five working days by the SAR Officer or a member of the ESAB Team. The Officer may contact the referrer to discuss the referral and may advise the referrer regarding other appropriate routes. Following the receipt of the referral form, the Officer will send an ESAB Safeguarding Adult Review information scoping request to relevant partners, who are likely to have had contact with, or provided services for, the adult at risk. Agencies must complete the request and return it to the ESAB Team within 10 working days. The Officer will collate information and present it to the ESAB SAR Committee, to assist with next steps in the decision-making process. The Officer must also inform the Independent Chair of ESAB and the Director of Adult Safeguarding and Quality Assurance that a SAR referral has been received.

Rapid Review Scoping Report

On receipt of responses to the information scoping request the SAR Officer will compile a report for the next SAR Committee. The Committee is made up of representatives from the ESAB partner agencies, and all statutory members (Adult Social Care, Police and Clinical Commissioning Groups) must be represented. All Committee members will ensure attendance to review the cases, identify learning and share decision making. The Committee must also take legal advice from the Board's legal adviser, when necessary.

In accordance with Section 44 Care Act 2014 and its Statutory Guidance the scoping report enables:

- facts to be established, (as far as possible at that point), and if enough information has been gathered
- decisions in relation to any immediate safeguarding intervention that may need to be made and identification of any immediate safeguarding improvements
- the sharing of immediate learning
- decisions on next steps i.e. to undertake a Safeguarding Adult Review or not, or to undertake an alternative review.

Rapid review scoping reports will be based the following principles, and action learning and research methodology:

- learning and improvement
- recognition and due regard that adult safeguarding is complex, bound by a wide level of specific legislation
- who did what and how, and underlying reasons at the time
- what was known at the time, not hindsight.
- relevant research and case evidence to inform findings and learning
- making Safeguarding Personal and a person-centred approach

The SAR Committee should also consider whether any other review or learning process has already commenced that may also identify and share lessons learned, or which ESAB could potentially participate in to avoid duplication (e.g., Domestic Homicide Review, Learning Disabilities Mortality Review (LeDeR) or Serious Incident process), and provide clarity about governance. (See Links to other reviews).

It is the responsibility of the SAR Committee to make one of the following recommendations to the ESAB Independent Chair:

- conduct a SAR under the mandatory duty
- conduct a SAR under the discretionary duty
- recommend a single agency review (where the duty is not met)
- decline the SAR request but set out learning that has been identified through the Rapid Review and make recommendations how learning can be taken forward.

The recommendation will include supporting rationale, any parallel processes and noting reasons for any delay.

Decision Making by the Independent Chair

The Independent Chair of ESAB will consider the recommendations of the SAR Committee and makes the final decision as to whether to commission a SAR, or not, with the choice of requesting more information if needed. Should the Independent Chair make a decision contrary to the Committee's recommendation, the case is referred back to the Committee for further consideration.

Information Governance

Section 45 of the Care Act places a legal duty on organisations to comply with requests for information that are received from Safeguarding Adults Boards that may assist with SARS. If ESAB requests relevant information from an organisation or person, for the purpose of a SAR, Section 45 of the Act creates a legal duty for that body or person to share information with ESAB, where the information requested by the SAB will enable or assist the Board to perform its functions, which include undertaking SARS. Organisations are required to give due consideration to the Data Protection Act 1998 and General Data Protection Regulations, but this should not be used as a reason to withhold information.

Once it is known that ESAB has received a SAR referral, agencies involved should secure case records to guard against loss or interference, whist still enabling professional duty to be carried out. All agencies also have a responsibility for promoting confidentiality and sensitivity in the co-ordination and management of the SAR process. All reports must indicate their confidential nature and be securely shared in accordance with each agency's information governance procedures. No sensitive or person identifiable information 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 esab@essex.gov.uk about this and then immediately delete the request and or any associated emails.

Freedom of Information Act 2000 (FOIA)

As a general rule, agencies involved in a SAR, deal with individual requests, under the FOIA, in accordance with their own procedures, as SABs are not a *'public authority'* as set out under the Schedule to the Act and are therefore exempt from requests for disclosures of information. Only information that has voluntarily been made public or is accessible under other legislation (e.g., Data Protection Act) will be available to others.

Records and retention

ESAB is responsible for all SAR referrals and subsequent documents will be stored in a secure electronic folder, along with records of referrals and decisions. Material generated by the SAR process is third party material and belongs to the agency who supplied it and any requests for information must be directed to the individual agency. Records will be retained for 7 years in accordance with the Essex County Council Retention Schedule.

Communication

ESAB's SAR Officer will inform the referrer of the decision, in writing. If SAR is to proceed, the Officer will make write to the individual, their family/carers, or representatives. If a decision is made not to contact the family, a formal record will be made of reasons why. In addition, where appropriate, the ESAB Independent Chair will consider notifying:

- partner agencies of the Board
- Care Quality Commission
- relevant regulatory body
- NHS England

When a decision is made not to conduct a SAR, the outcome will be recorded and shared with the referrer and appropriate agencies. SAR referrals that are not progressed are recorded in ESAB's secure electronic filing system.

Inclusion of the adult; family; carer or representatives

ESAB will include the above in the SAR process in accordance with the Making Safeguarding Personal principles. Early identification will be necessary of the subject's preferred contacts, however if the subject is deceased, family members should be sought via likely contacts, such as any next of kin or carer records. The consent of the adult, or their family or representative is not required for a SAR to take place, or to publish findings of the same, however ESAB will make all possible steps to seek views and resolve any concerns that may arise.

The Care Act 2014 Statutory Guidance indicates that adults, their families and/or representatives should be invited and supported to contribute to SARs, in order to enable an inclusive approach and ensure that their views and perspectives are fully considered. The SAR Officer will arrange for contact to be made with the adult, family and/or representative, to inform them that ESAB have made a decision to conduct a SAR; invite them to be involved; advise how this would occur e.g. telephone conversation, written communication and or a face to face meeting and identify any support or adjustments they would need to facilitate that involvement.When relevant individuals have been identified, it is good practice to establish who will be the main point of contact. If one family member advises that they are representing other family members, this must be put in writing to the SAR Officer and be signed by each of the represented members. Following agreement regarding the point of contact, or nominated parties, the SAR Officer will establish what outcomes the representative(s) would like to achieve from the SAR, manage their expectations with sensitivity and compassion, and ensure that the focus remains on the subject, keeping the person at the centre of the SAR.

The SAR Officer will maintain contact with the adult and or representatives throughout the SAR and will share the draft of the Overview Report with the nominated representatives; discuss a naming protocol, to maintain their confidentiality and advise regarding future publication (considering sensitivities, such as an anniversary of a death). An advisory information leaflet has been developed to support people who may experience this process. (see Appendix Four)

The Care Act 2014 requires each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or a SAR, where the adult would have '*substantial difficulty*' being involved in the process, and where there is no other suitable person to represent and support them. Further information can be found at Appendix Five.

Inclusion of the alleged persons

The Care Act 2014 Statutory Guidance comments that in some cases it may be helpful to communicate with the person who caused the abuse and neglect, which may involve liaison with other professionals, working with, or trained to work with, people who abuse. The SAR Committee, in consultation with ESAB's Independent Chair will consider if this is appropriate, and if so, how this would be facilitated. The SAR subject and nominated representatives, should also be consulted for their views.

Involving staff

Staff who have worked directly with the subject, should be notified by their employing organisation that a SAR will be undertaken for a case that they were involved in. They should be encouraged, enabled, and supported to contribute directly to SARS and given support in line with their organisation's HR policies. The SAR Officer will contact the organisation to seek involvement of their staff member in the SAR, if appropriate. Staff may also be invited to attend Practitioner Learning Events.

Links with other reviews

ESAB acknowledges the interface with other organisation's policies and procedures, particularly where there may be a statutory responsibility to investigate specific incidents, for example health or criminal investigations. ESAB recognises that a variety of investigation methodologies may be applied and promotes the ever increasing need to work collaboratively, in order to gain learning to inform systematic learning and improvement. It is probable that in some circumstances other statutory requirements and SARs may overlap (such as criminal investigations; HM Coroner's Inquest; Domestic Homicide Review (DHR), Learning Disability Mortality Review (LeDeR) or Serious Incident investigation, none of this however should prevent a referral being made, and the SAR Committee must discuss; manage and record any such parallel processes.

Learning Disability Mortality Reviews (LeDeR)

The Learning Disability Mortality Review programme (LeDeR) was implemented to review the deaths of people with a learning disability. Whilst this type of review is not statutory, key learning will be gleaned from such investigations and should be taken into consideration if one is running alongside a SAR.

Domestic Homicide Reviews (DHR)

DHR were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004) and are multi-agency reviews of the circumstances where the death of a person (16 or over), has or appears to have, resulted from violence, abuse, or neglect by:

- a person whom he/she was related to, or had been in an intimate personal relationship, or
- a member of the same household.

The DHR identifies the lessons to be learned, particularly in relation to the way in which local professionals and organisations worked individually and together to the safeguard victim(s); and how lessons will be acted on. The ESAB Board Manager and SAR Officer are standing members of the Essex DHR Core Group. This enables early identification of referrals, which involve an adult with care and support needs and enables ESAB's participation in the DHR processes, ensuring joint reviews are considered where appropriate.

HM Coroner enquiries and Inquests

Her Majesty's Coroners are independent judicial office holders, appointed by a local council and they are responsible to establish and investigate cause of a death, reported to them if it appears that:

- the death was violent or unnatural
- the cause of death is unknown
- the person died in prison, police custody, or another type of state detention, including having a Deprivation of Liberty Safeguard (soon to be a Liberty Protection Safeguard).

The role of the Coroner is to determine who the deceased person was and how, when and where they came by their death. When the death is suspected to have been either sudden with unknown cause, violent, or unnatural, the Coroner decides whether to hold a post-mortem examination and, if necessary, an Inquest. An Inquest is a public court hearing held by the Coroner to establish who died and how, when and where the death occurred. Where a death has been referred to HM Coroner for investigation, the SAR Officer should contact the local HM Coroner's Office to advise of the SAR referral and seek any necessary information. The SAR Committee and ESAB Independent Chair will consider whether the SAR process can go ahead, prior to an Inquest being held and inform the HM Coroner of ESAB's decision.

SAR requests from the Coroner

The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall into one of the following categories:

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

In addition, the Coroners and Justice Act 2009, places a duty on the Coroner to issue reports to a person, organisation, local authority or government department or agency, where the Coroner believes that action should be taken to prevent future deaths (Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, formerly known as Rule 43). Recipients are required to respond to the Chief Coroner who will in most cases publish the reports and responses If HM Coroner contacts ESAB about any of these situations, ESAB will give careful consideration to conducting a SAR.

Criminal Justice proceedings

Where relevant, the SAR Committee should seek advice from the police or Crown Prosecution Service (CPS) to ensure that a SAR will not prejudice criminal proceedings. The police or CPS are responsible for advising ESAB whether a SAR should be postponed or not, until a criminal case has concluded. The SAR Committee should consider whether a single agency review should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties. It may be helpful, when a parallel process is in place, to establish, at the outset, all the relevant areas that need to be addressed, in order to reduce the potential for duplication, both for families and organisations.

The SAR Officer, ESAB Board Manager or ESAB Independent Chair will be responsible for making contact with the Chair of any other review to explore the feasibility of jointly commissioning certain aspects and aligning the reviews, where practicable.

Cross Boundary Safeguarding Adult Reviews

There are cases where adults have moved from their 'home' area and may be placed out of area. In this case a SAR should be carried out by the SAB within the location where the incident took place. Early consideration should be given to inviting both inviting or sending a representative to or from the SAB to ESAB. The SAB with locational responsibility will need to share learning and ensuring and that recommendations/actions for their own area are implemented, however it would be the responsibility of ESAB to deploy any relevant recommendations, made for the Essex partners.

Upon receipt of an out of area SAR alert, the SAR Officer must notify the ESAB Independent Chair, take advice and then consult with the other SAB, to determine how to share information, and determine ESAB participation levels. The Officer will facilitate information gathering, on behalf of the other SAB, with Essex partners.

Methodologies

Following receipt of a SAR referral, the SAR Committee will decide whether the case meets the duties to conduct a SAR under Section 44 Care Act 2014 (see SAR Referral Consideration and Decision Making) and subsequently the most appropriate methodology to use for the circumstances. SARs must be conducted in accordance with Section 44, and methodology must be considered in light of individual circumstances and proportionality.

The Care Act outlines the expectation that SABs will commission and learn from SARs, and states:

'The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.' (Section 14.164)

There are many ways for ESAB to achieve learning from SARs, and it is important that options are in place. Decisions regarding methodologies for particular SARs will be recommended to the Independent Chair, who will make the final decision. The Care Act Statutory Guidance indicates that whichever methodology is deployed, the following should be in place:

- SAR Chair – this person should be independent of the case, and of the organisations, whose actions are being reviewed, and they should possess appropriate skills, knowledge, and experience.
- SAR Panel – they will scrutinise information submitted to the SAR; be proportionate to the nature and complexity of the SAR and be comprised of a minimum of three members in addition to the Chair and hold a level of independence from the case under review.
- Terms of reference – these must be drawn up by the Panel and can be assisted by the SAR Author and Chair and be openly available.
- Early discussions with the adult and their family, carers, and friends – to agree to the level of participation and to manage expectations, whilst independent advocacy, remains a consideration.
- Appropriate involvement of professionals and organisations who were working with the adult – to contribute their perspectives without fear of being blamed for professional actions taken, and decisions which were made in good faith.
- SAR Overview Report and recommendations - including the type of abuse.

ESAB will ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. 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.

Irrespective of the methodology chosen, all reviews should apply the following principles:

- a culture of continuous learning and improvement across the organisations involved and to promote the wellbeing and empowerment of adults at risk, identifying opportunities to draw on what works well, and promoting good practice
- approach to be proportionate to the scale and level of complexity of the issues being examined
- weighed against the cost, resource and length of time expected to conduct the review

The following questions should be raised when selecting a SAR methodology:

- is the case complex, involving multiple abuse types and/or victims?
- is significant public interest anticipated?
- is large-scale staff/family involvement wanted/appropriate?
- are there any parallel processes and could the SAR methodology impact on them?
- Is the type of suggested review proportionate to the scale and level of complexity of the issues being examined?
- what is the quickest and simplest way to achieve the learning?
- is a more appreciative approach required to review good practice?
- are trained SAR authors available for the method selected?
- can value for money be demonstrated?

ESAB has developed a SAR Quality Assurance framework, which will be utilised during each SAR undertaken and will be shared with each SAR Author at point of commissioning. This is a tool which incorporates the SCIE SAR Quality Markers and includes a framework for the whole SAR process, providing a consistent and robust approach to quality assurance. The QA framework is based predominantly on established principles of effective reviews / investigation as well as experience, expertise, and ethical considerations.

The scope and Terms of Reference of the SAR

Once the decision has been made by the ESAB Independent Chair that a SAR will be conducted, the SAR Committee/Panel will propose the terms of reference and scope of the review to the ESAB Independent Chair for approval. Relevant issues to consider include:

- what are the most important issues to address in identifying the learning from this specific case?
- what time period should be considered?
- what history would help to better understand the context of events leading to the death or serious incident?
- how can information best be obtained and analysed?
- which agencies and professionals should be asked to submit reports or contribute?
- how will the process dovetail with any parallel investigations? (see links with other reviews) e.g. a combined SAR and DHR may be more effective in addressing relevant questions preventing duplication
- should an expert be consulted to help understand crucial aspects of the case? e.g., advice on the interface between the Mental Capacity Act and the Mental Health Acts
- are there specific considerations regarding equality, diversity, language, and inclusion?
- if the subject or alleged perpetrator/s were subject to a Multi-Agency Risk Assessment Conference (MARAC) or Multi Agency Public Protection Arrangements (MAPPA), there will be a requirement to consider the need for a Memorandum of Understanding (MOU) for the release of minutes from the relevant meetings.
- the local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a SAR and where an independent advocate has already been arranged under s67 Care Act, or under MCA 2005, then, unless inappropriate, the same advocate should be used
- how should friends, family members and other support networks (for example, co- workers and employers, neighbours, etc.) and, where appropriate, the perpetrator/s, contribute to the review (including informing them of the terms of reference), and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process, taking account of possible conflicting views within the support network?
- how should matters concerning family and friends, the public and media be managed before, during and after the review, and who should take responsibility for this?
- learning from research; previous SARs and DHRs
- Is legal advice needed?

(This is not an exhaustive list).

Safeguarding Adult Review (SAR) Methodology

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight local and/or national lessons about safeguarding practice.

IMR and chronology requests

The SAR Committee will determine the terms of reference and confirm the agencies who need to complete an Independent Management Report (IMR). Once approved by the ESAB Independent Chair, they will formally request IMRs and a chronology of involvement, including an analysis of their practice. Agencies will be advised, that IMRs and chronologies will be shared with the SAR Author, as well as the SAR Panel and Committee, for the purpose of analysis and SAR progression. Guidance can be provided to enable agencies to focus their response on the specific issues identified by the SAR Committee.

SAR Author

When commissioning an independent author/reviewer to undertake a SAR, consideration will be given to their experience and expertise, which may include seeking testimonials from previous commissions. Flexibility to select an independent reviewer without the necessity of a lengthy selection process should be the norm. The SAR Committee is responsible for considering the most appropriate author for each case, and a recommendation will be made to the ESAB Independent Chair. If this results in non-approval the Committee must find a replacement.

The author will operate on a temporary contract and invoice ESAB accordingly and will give assurance that they meet the requirements of the General Data Protection Regulations and management of confidential information. SAR Authors will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others
- expert facilitation skills
- ability to handle potentially sensitive, complex, and challenging group dynamics
- collaborative problem-solving experience and knowledge of participative approaches
- analytical skills and ability to manage qualitative data
- knowledge of safeguarding adult and relative lawful compliance
- ability to promote an open, reflective learning culture

SAR Panel

Once commissioned, a SAR Panel will be established and led by the appointed Independent SAR Author/Chair and supported by the ESAB team. The SAR Officer is responsible for ensuring that all agencies are properly represented at the Panel and contribute to the process, completing tasks in timescales agreed, and reporting lack of engagement or other blockages to progress, to the SAR Committee. As an agreed principle, core membership of the SAR Panel is drawn from members of the SAR Committee to enhance their experience. Non-contributing agency SAR Committee members are invited to act as '*critical friends'*, to enhance experience and ensure integrity of process and adherence to SAR Procedure. The SAR 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 Author or ESAB team, e.g., ESAB members who are not involved in the case, but can offer independent scrutiny, challenge, or skills. The SAR Committee legal representative may be invited to also advise.

The SAR Panel will review all information provided and analyse the multi-agency practice, providing an opportunity for multi-agency learning and partnership challenge. The initial meeting will consider content of IMRs and main focus areas, (in accordance with the Terms of Reference). IMR authors will

be required to attend the first meeting to present findings, from their IMR and address any queries that arise. Prior to the meeting, copies of the IMRs must be passed through secure electronic systems to all the members of the Panel at least two weeks before hand. It may also be helpful to distribute the minutes from the SAR Committee meeting with the papers for the first Panel meeting. If requests for further information are made at the SAR Panel meeting, agencies will be given a response period.

The number of SAR Panels required will be considered by the SAR Officer when compiling the Independent Author's consultancy agreement. The number will remain under consideration, in consultation with Panel members and the Independent Author, throughout the process. Some level of email communication may reduce the number of meetings required.
The Independent SAR Author will draft the Overview report, Executive Summary, and recommendations. These will be submitted to the SAR Officer within an agreed timescale, to circulate to the members of the SAR panel in advance of their next meeting, for their consideration and comments. The SAR Panel will review the draft Overview Report and consider, with the Author, what recommendations should be made to improve practice. These considerations can include consultation with organisations involved to assure that recommendations are achievable. Any recommendations should be SMART (Specific, Timely, Achievable, Realistic, Timely).

Finalising the SAR report and approving the report

Once the SAR Panel members have agreed a final draft of the Overview Report, Executive Summary, and any draft action plan, it will be shared with the SAR Committee, where the Author will present the report. Following SAR Committee agreement and quality assurance (ESAB Quality Assurance Framework), the final draft must be submitted to the ESAB Independent Chair for comment/approval, prior to a final report being presented to the ESAB Executive and ESAB full Board.

The Overview Report will be presented to ESAB as soon as is practicable, following the ESAB Independent Chair's approval, and that of the ESAB Executive. The report will normally be presented by the Independent SAR Author and ESAB will consider approval, along with its recommendations, action plan and communications plan. ESAB may however, not always provide approval, and sometimes more work may be required.

Publication and report dissemination

The decision to publish an anonymised SAR on the ESAB website is the responsibility of ESAB, having considered any recommendations made by the SAR Committee to the Board. The views of the adult and/or family or representatives are considered, in relation to SAR publication decisions, however permission from others is not required in order for the Board to take a decision to publish a SAR. In the interests of transparency and sharing learning, it is lawful that ESAB publish SARs, in accordance with Section 14.166 Care Act 2014, unless there are compelling reasons not to do so. Publication decisions will be made on a case-by-case basis and blanket decisions must **never** be made as if that was to happen, ESAB could be open to a Judicial Review. Consideration will be given to the public interest, legal advice, and confidentiality. This may mean that some sections of the report are redacted. Should ESAB decide that neither the Overview Report nor Executive Summary are to be published, there must be a very clear rationale as to why this decision has been made e.g., if young siblings or employment could be affected. ESAB will also decide on whether to produce a reactive or proactive press statement.

Planning for publication should start early and communications about a SAR are decided on a case-by-case basis. In advance of the SAR publication date, the press statement should be drafted by the ESAB team, in conjunction with Essex County Council's Communications Team and approved by the ESAB Independent Chair. This statement will be shared with relevant agencies, as appropriate. ESAB members are required to make arrangements to disseminate the SAR report, recommendations, and action plans within their agencies.

Implementing SAR report recommendations

It is the responsibility of the individual organisations to progress and monitor their own agency/service recommendations and to make service improvements. Via the SAR Committee, ESAB will monitor the evidence of action plan outcomes; that learning has been embedded and that lessons have been shared across the relevant organisations in Essex. The SAR Committee will report on progress of the action plans to ESAB at the ESAB Executive, along with any concerns regarding non-compliance or delays in implementation.

Learning from Safeguarding Adult Reviews

Where appropriate, either the SAR Overview report or Executive Summary will be published on the ESAB website to allow practitioners and other SABs to learn from our experience. The SAR Committee is responsible for determining the most effective means of sharing learning from SARs. Such methods may include developing on-line learning modules, practitioner briefing guides or holding partner learning events. The SAR Committee will be supported by the ESAB team who will assist with developing any learning resources or facilitating learning events.

Concluding a SAR

The SAR will only be completed when ESAB is satisfied that all actions from the SAR action plan have been finalised and embedded into practice. The SAR Committee is responsible for determining when the SAR is concluded and that the context and outcomes of the SAR are recorded within ESAB's Annual Report.

Media considerations

It is critical that there is a cohesive approach and response to media enquiries resulting from a SAR and that ESAB and individual agencies 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 ESAB, the ESAB Independent Chair and Essex County Council. In all cases a reactive press statement will be drafted and made available should there be media enquiries. If required, ESAB's Independent Chair will normally address any media enquiries arising from the SAR, on behalf of ESAB.

Escalation and Appeals

Where there is challenge to any matters relating to a SAR, concerns should be communicated to the ESAB Board Manager, who will advise the Independent Chair and make an initial response within five working days to advise on the most appropriate course of action.

Legal advice

Legal advice will be supplied by Essex County Council's legal team, in the first instance unless a conflict of interests should arise, in which case independent legal advice will be sought, or legal advice from the individual organisation who may be subject of any concern.

Allegations of misconduct

Safeguarding Adult Reviews do not explore whether an organisation or individual is responsible, and as noted herein, existing criminal, disciplinary and regulatory processes are in place, set within individual organisations, and where relevant, additional investigations will commence before or parallel to the SAR.

If an issue of this nature arises, the relevant organisation will be notified by the ESAB Board Manager. Should information regarding significant, individual and/or organisational omission be received that requires notification to a statutory body, ESAB or another relevant agency will ensure this is completed without delay.

Timescales

The SAR Author will be responsible for ensuring completion of the SAR and sharing the report within an agreed time frame, which is usually within six months from the date that the SAR commences. If the SAR Author believes that they will not be able to fulfil the timescale set, such as due to potential prejudice regarding related criminal proceedings, or owing to the implications of alternative parallel processes, an alternative timescale should be agreed with the SAR Officer. Every effort, however, will be made, whilst the SAR is in progress, to capture early learning points and advise agencies on corrective action. The SAR Committee will monitor compliance with the agreed timescales.

Budgetary considerations

There will be a need to consider the budgetary requirements for undertaking a SAR or other review processes, which is the shared responsibility of ESAB. 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) 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."

Responsibilities of Essex Safeguarding Adults Board

ESAB will consider the final draft of the Overview Report and will either approve the report and its recommendations or return it to the SAR Committee for further work to be completed. Once ESAB has agreed the Overview Report, it will:

- ensure that recommendations are endorsed at a senior level by each agency
- clarify to whom the report or parts of the report should be made available and agree the means to carry this out
- disseminate key findings to interested parties - as agreed
- confirm monitoring and implementation of recommendations

The SAR will then be published on the ESAB Website (publication and report dissemination**).** ESAB will include findings from SARs completed in the reporting year, and recommendations, and if a particular recommendation was not deployed, an explanation will be provided.

Appendix One – SAR referral form

Referral Form
SAR1

Essex Safeguarding Adults Board

Safeguarding Adults Review (SAR)

ESAB's SAR Committee considers every referral on the basis of whether it meets the criteria for a Safeguarding Adult Review.

Mandatory Reviews (Section 44 (1-3) Care Act 2014)

ESAB 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 ESAB, its members or organisations worked together to safeguard the adult

AND

b) The person died and ESAB knows or suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

c) The person is still alive but ESAB knows or suspects they've experienced serious abuse/neglect, sustained potentially life-threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

The Care Act guidance outlines that in the context of SARs something can be considered as 'serious abuse or neglect' for example:

- the individual would have been likely to have died but for an intervention
- the individual has suffered permanent harm
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects)
- the individual has suffered serious sexual abuse.

Discretionary reviews (Section 44(4) Care Act 2014)

ESAB may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support (whether or not the local authority has been meeting any of those needs). These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, but which may not meet criteria for a Safeguarding Adult Review.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. **Further information about Safeguarding Adult Reviews can be found within the ESAB Safeguarding Adult Review Procedure which can be found at** https://www.essexsab.org.uk/media/2493/safeguarding-adult-review-procedure

Please complete all sections and include as much information as possible to enable SAR Committee members to make a proportionate decision. The completed referral must be reviewed and authorised by a senior manager and submitted to the ESAB team to the secure email address at esab@essex.gov.uk If you have any questions, please do not hesitate to contact the ESAB team.

1. **Referrer**

Name:	
Title:	
Agency (where applicable):	
Address:	
Telephone number:	

Email address:	

2. Senior Manager Authorisation (where applicable)

Name:	
Title:	
Telephone number:	
Address:	
Email address:	
Date referral authorised:	

3. Details of the adult subject of this referral

Adult	
Name:	
Date of birth:	
Ethnicity	
Address:	
Date of death (where applicable):	
Details of GP:	
NHS number (if known):	
Health (physical):	
Health (mental):	
Details of adult's care and support needs:	

4. Details of the representative/family of the adult with care and support needs

Does the adult have any family or representative as far as you are aware	☐ Yes ☐ No
Are they aware of the SAR referral?	☐ Yes ☐ No
Family member/representative contact name	
Relationship to the adult	
Contact details:	

5. Agencies involved:

Agencies involved:	

6. Person(s) or Organisation(s) Alleged Responsible to have Caused Harm or Neglect:

Name (individual or organisation):	
Date of Birth (where applicable):	
Address:	

Relationship with adult (where applicable):	

7. Referral reason(s)

Please refer to the front page of this referral form and include in detail how you feel this case meets the criteria for a Safeguarding Adults Review **responding fully to each separate criteria**. **For the circumstances to meet the criteria there must be concerns about how separate agencies worked together.**	**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** Supporting information:
	b) the adult has died (suspected to be resulting from abuse or neglect) Supporting information, to include what the abuse and neglect consisted of: Cause of death if known:
	c) the adult is still alive and suspected to have experienced abuse or neglect Supporting information, to include what the abuse and neglect has consisted of:
Current Section 42 adult safeguarding enquiry:	☐ Yes ☐ No ☐ Has been ☐ Not known Outcome (if appropriate):
Category of alleged abuse (if any):	☐ Physical ☐ Sexual ☐ Psychological or emotional ☐ Self-neglect ☐ Financial ☐ Modern slavery ☐ Domestic abuse ☐ Organisational ☐ Neglect or acts of omission ☐ Discriminatory
What other learning/review processes have been followed? (please detail) And if so: 1. What did they achieve 2. How has that learning been disseminated 3. What impact has it had? (please detail on all) 4. Are any parallel processes still ongoing?	
Please detail any other relevant information that will enable the SAR Committee to reach a decision about how to	

respond to this referral.	

8. Referrer signature

Signature:	
Date:	

Appendix Two – SAR initial information request

Essex Safeguarding Adults Board

Safeguarding Adult Review – Initial information request

Essex Safeguarding Adult Board (ESAB) has received a Safeguarding Adult Review (SAR) referral in which your agency may have provided services or had contact with the adult involved. This information request is submitted to enable the SAR Committee to consider the SAR referral and relevant information regarding the adult and establish whether the duties under Section 44 Care Act 2014 have been met. These duties are detailed in the box below.

Mandatory reviews (Section 44 (1-3) Care Act 2014)

ESAB 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 ESAB, its members or organisations worked together to safeguard the adult

AND

b) The person died and ESAB knows or suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

c) The person is still alive but ESAB knows or suspects they've experienced serious abuse/neglect, sustained potentially life-threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

The Care Act guidance outlines that in the context of SARs something can be considered as 'serious abuse or neglect' for example:

- the individual would have been likely to have died but for an intervention
- the individual has suffered permanent harm
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects)
- the individual has suffered serious sexual abuse.

Discretionary reviews (Section 44 (1-3) Care Act 2014

ESAB may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support (whether or not the local authority has been meeting any of those needs). These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, but which may not meet criteria for a Safeguarding Adult Review.

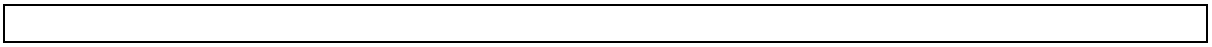
In accordance with Section 45 of the Care Act 2014, you are requested to check your organisations records for any involvement with the adult detailed below and advise the Board if involvement is identified. Please also provide us with any relevant information that may assist us in deciding whether the criteria for conducting a SAR have been met.

Please provide information for the period between and **XXXX and XXXX**. Should you have any information that you believe may be relevant from before this time, we would welcome you to include this also.

You are requested to provide this information, via email to esab@essex.gov.uk by (***10 dates from service)***

Details of the Adult	
First name	
Preferred name	

Surname	
Address	
Date of Birth	
Date of Death (if applicable)	
Ethnicity	
Your details	
Your name	
Your role	
Agency name	
Agency address	
Your telephone number	
Your email address	
Your agency's chronology Provide your agency contact with the adult in chronological order for the time period specified above, include the date of commencement and completion of service.	
Date	Event/Reason
Brief analysis of individual and / and agency practice. *(Please identify any outstanding practice or potential learning).*	
Are there any areas for concern around partnership working?	
Are you aware of the involvement of any other agencies? If yes, please give details.	
Please include any further relevant information that you wish to bring to the attention of the SAR Committee.	



Appendix Three – Individual Management Review (IMR) template

INDEPENDENT MANAGEMENT REPORT (IMR)

AGENCY NAME:

IMR FOR: Name - DOB/DOD
The period to be covered by the review will be XXXX to XXXX.

* Please use real names of those involved when completing this IMR as these will be anonymised for the final overview report.

* Please also adhere to Data Sharing policies for sharing restricted information/documents.

AUTHOR DETAILS	
Name	
Role	
Office Location	
Telephone Number	
Email Address	
Completion Date	
Author Signature	

* *It is the responsibility of the signatory of this report to ensure that all information provided is true and accurate to the best of your knowledge.*

SENIOR APPROVAL/SIGN OFF	
Name	
Role	
Date	
Signature	

1.INTRODUCTION

1.1 Reason for Review

**To be added in from the reason given by the chair at the start of the process.*

1.2 Terms of Reference

**Insert here the specific Terms of Reference agreed by the SAR Committee.*

1.3 Details of parallel reviews/processes

**Insert any details of parallel processes/reviews that may be taking place.*

1.4 Contextual Information

Consider how the service was delivered at the time of the incident and how it is delivered presently.

Examples of the type of information that would be useful are as follows:

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organisational change
- Unallocated cases
- The social and community context
- Management and Supervision
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal Advice
- Findings of any audits or inspections
- Significant National/Local Policy changes.

1.5 Methodology

Record the methodology used including extent of document review and interviews undertaken including:

- How the agency carried out the review.
- Details of documents seen.
- List of interviews and dates.
- List of interviews and dates (a written record of interviews should be made and shared with interviewee).
- Details of information not available/not considered (with reasons).
- Details of how agency staff were kept informed of the purpose and process of the Individual Agency Review.
- Details of staff involved by name and job title for the benefit of the Panel only. The overview report will be completely anonymised.

2. FAMILY COMPOSITION

2.1 Table of Family Composition and Non-Family members who are significant to the case under review (if known).

Name	Gender	Date of Birth	Relationship	Ethnic Origin	Address

3. Summary of involvement

A short summary/narrative of agencies involvement of key events with the full Chronology attached as an appendix over the period of time set out in the review's terms of reference. State when the victim/family/perpetrator was seen including antecedent history where relevant. Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

4. Analysis of Involvement

Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.

Address terms of reference specifically but also consider further analysis in respect of key critical factors, which are not otherwise covered by the terms of reference.

Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.

Areas of consideration:

- How did agencies work together? Please comment as necessary.
- What problems were experienced in the preparation of the report?
- Were practitioners sensitive to the care needs of the adult in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about an adult?
- Did the agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare.
- Were the internal adult safeguarding procedures appropriate?
- Were the decisions and actions taken in line with policies and procedures within the agency?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the adults involved? Do assessments and decisions appear to have been reached in an informed and professional way?
- When, and in what way, were the adult's wishes and feelings ascertained and considered? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic, and religious identity of the adult?
- Were more senior managers, or other agencies and professionals, involved at points where they should have been?
- Was the work in this case consistent with agency and SET policy and procedures for safeguarding adults and wider professional standards?

5. Detailed factual chronology (Completion of the Chronolator if this has not already taken place))

This should include any inter-agency contact as well as key actions and events that took place

6. EFFECTIVE PRACTICE/LESSONS LEARNT

What do we learn from this case?

- Comment upon changes to guidance / working practises that has changed which would have mitigated this.
- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children and adults?
- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?
- Are there implications for current policy and practice?
- Information sharing.

Recommendations

Recommendations should be focussed on the key findings of the IMR and be specific about the outcomes which they are seeking. Recommendations identified that concerning other agencies can be reported to the panel for consideration.

IMR recommendations must be SMART (Specific, Measurable, Achievable, Realistic and Timely) and should include: -

- What changes (if any) could be made to your agency's procedures?
- What changes (if any) could be made in inter-agency working in the light of this case?
- What action within the agency should be taken in the light of its findings, and in what timescale?

- What areas of good practice are there? Could these be expanded or practice improved?
- What action should be taken by whom and by when?
- What outcomes should these actions bring about, and in what timescales?
- How will the agency review whether they have been achieved?
- Are there any immediate statutory requirements for the notification of concerns and are they likely to be any media handling issues.

7. APPENDIX

A – CHRONOLOGY (USE TEMPLATE)

Appendix Four – Information leaflet

Essex Safeguarding Adults Board

Information for adults and/or family members about Safeguarding Adult Reviews

When are Safeguarding Adult Reviews held?

- Safeguarding Adult Reviews are held if it is felt that there could be valuable learning to be gained from a particular case.
- The people who are responsible for deciding when a Safeguarding Adult Review is needed are the group of senior managers and officers who have responsibilities for safeguarding work (keeping adults who may be vulnerable safe). These are the local agencies (such as the police, the health services, adult social care, voluntary organisations, housing associations, the ambulance service etc.). This group of managers is called Essex Safeguarding Adults Board (SAB).

What is the purpose of a Safeguarding Adults Review?

- To promote effective learning and improvement to services and how they work together
- To learn lessons that will help to prevent future harm
- To understand what happened and why
- Where possible to provide explanations for service users, family, and friends
- The purpose of case review is not to blame or hold individual staff or organisations to account - there are other processes that will do that if necessary (e.g., criminal proceedings, disciplinary proceedings).

What does the Safeguarding Adult Review process involve?

- The review will involve the front-line staff who were directly involved in the case
- Wherever possible service users and families are usually invited to contribute to the process
- The review is usually led by an independent and suitably skilled Lead Reviewer.

What kind of outcomes can we expect from a Safeguarding Adult Review?

- The findings and recommendations from the review will be considered by Essex Safeguarding Adults Board (SAB), and the learning will be shared with staff across all the agencies.
- The Board may also wish to share key learning with the service user and family members and to show how they are going to take forward the findings and recommendations. The actions may also be published in the annual SAB report and the report will be published on the ESAB website (unless there are compelling reasons not to do so).

Appendix Five – Independent Advocacy

Local Authorities must arrange for an independent advocate to support and represent an adult or family member who is the subject of a Safeguarding Adult Review if should an independent advocate not to be available, the individual would experience substantial difficulty in doing one of more of the following:

(a)understanding relevant information.
(b)retaining that information.
(c)using or weighing that information as part of the process of being involved.
(d)communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means).

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.

Effective safeguarding is about seeking to promote an adult's rights as well as about protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect. It enables the adult to understand both the risk of abuse and actions that she or he can take, or ask others to take, to mitigate that risk.

It is critical in this particularly sensitive area (whether an enquiry or a SAR) that the adult is supported in what may feel a daunting process which may lead to some very difficult decisions. An individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed, or upset that independent advocacy to help them to be involved will be crucial.

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.

Identifying substantial difficulty in engaging

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. Where an independent advocate has already been arranged under the Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate should be used.

Local authorities must consider for each person, whether they would have substantial difficulty in engaging with the safeguarding process. The Care Act defines four areas where a substantial difficulty might be found, which are set out below.

The first area to consider is *'understanding relevant information'*. Many people can be supported to understand relevant information if it is presented appropriately and if time is taken to explain it. Some people, however, will not be able to understand relevant information, for example if they have advanced dementia.

The second area to consider is 'retaining information'. If a person is unable to retain information long enough to be able to weigh up options and make decisions, then they are likely to have substantial difficulty in engaging.

The third area is *'using or weighing the information as part of engaging.'* A person must be able to weigh up information, in order to participate fully and express preferences for or choose between options. For example, they need to be able to weigh up the advantages and disadvantages of moving into a care home. If they are unable to do this, they will have substantial difficulty in engaging.

The fourth area involves 'communicating their views, wishes and feelings'. A person must be able to communicate their views, wishes and feelings to aid the decision process and to make priorities clear. If they are unable to do this, they will have substantial difficulty in engaging.

For example, a person with advanced dementia, significant learning disabilities, a brain injury or mental ill health may be considered to have substantial difficulty in communicating their views, wishes and feelings. But equally a person with Asperger's may be so considered, as may a frail older person who does not have a diagnosis but is confused as a result of an infection, or a person who is near the end of their life and appears disengaged from involvement and decision-making.

Mental Capacity Act 2005

Some of the people who qualify for advocacy under the Care Act may also qualify for advocacy under the Mental Capacity Act 2005 where a specific decision is being made and specific criteria are met (see SET MCA Policy and Procedure). It is almost always in an individual's best interests to seek to ensure wherever possible that the same advocate provides support under both the Care Act and the Mental Capacity Act.

Both Acts recognise the same areas of difficulty, and both require a person with these difficulties to be supported and represented, either by family or friends, or by an advocate in order to communicate their views, wishes and feelings.

An appropriate individual to facilitate the person's involvement

Local authorities must consider whether there is an appropriate individual (or individuals) who can facilitate a person's involvement in the SAR process, and this includes three specific considerations.

First, it cannot be someone who is already providing the person with care or treatment in a professional capacity or on a paid basis (regardless of who employs or pays for them). That means it cannot be, for example, a GP, or a nurse, a key worker or care and support worker.

Second, the person who is to be supported must agree to the particular individual supporting them if the person has the capacity to make this decision. Where a person does not wish to be supported by a relative, then the local authority cannot consider the relative appropriate. The person's wish not to be supported by that individual should be respected regardless of whether the person is assessed to have or lack capacity. The person must agree to the appropriateness of the individual who is proposed to support them. If the person lacks the capacity to make a decision, then the local authority must be satisfied that it is in a person's best interests to be supported and represented by the individual.

Third, the appropriate individual is expected to support and represent the person and to facilitate their involvement in the processes. It is unlikely that some people will be able to fulfil this role easily, for instance a family member who lives at a distance and who only has occasional contact with the person, a spouse who also finds it difficult to understand the SAR process, a friend who expresses strong opinions of her own prior to finding out those of the individual concerned, or a housebound elderly parent. It is not sufficient to know the person well or to love them deeply; the role of the advocate is to support the person's active involvement with the SAR processes.

If the local authority decides that they are required to appoint an independent advocate as the person does not have friends or family who can facilitate their involvement, the local authority should usually still consult with those friends or family members when appropriate.

It is the local authority's decision as to whether a family member or friend can act as an appropriate person to facilitate the individual's involvement. It is the local authority's responsibility to communicate this decision to the individual's friends and family where this may have been in question and whenever appropriate. The overall aim should be for people who need advocacy to be identified and when relevant, receive consistent support as early as possible and throughout the SAR process. The local authority may be carrying out a SAR relating to two people in the same household. If both people agree to have the same advocate, and if the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent the two people. If

any of the people involved in the review consider that it would be better to have different advocates, then separate advocates should be provided.

Who can act as an advocate?

Advocates must have:

- a *suitable level of experience:* this may, for example, be in advocacy or in working with those groups of people who may have substantial difficulty in engaging with statutory processes.
- *appropriate training:* this may, for example, initially be training in advocacy or dementia, or working with people with learning disabilities. Once appointed, all independent advocates should be expected to work towards the National Qualification in Independent Advocacy (level 3) within a year of being appointed, and to achieve it in a reasonable amount of time.
- competency in the task: this will require the advocacy organisation assuring itself that the advocates who work for it are all competent and have regular training and assessments.
- integrity and good character: this might be assessed through interview and selection processes; seeking and scrutinising references prior to employment and on-going DBS checks.
- the ability to work independently of the local authority: this would include the ability to make a judgement about what a person is communicating and what is in a person's best interests, as opposed to in a local authority's best interests, and to act accordingly to represent this.
- arrangements for regular supervision: this will require that the person meets regularly and sufficiently frequently with a person with a good understanding of independent advocacy who is able to guide their practice and develop their competence.

The advocate must not be working for the local authority, or for an organisation that is commissioned to carry out assessments, care and support plans or reviews for the local authority. Nor can an advocate be appointed if they are providing care or treatment to the individual in a professional or a paid capacity.

The Role of the Independent Advocate

Advocates will decide the best way of supporting and representing the person they are advocating for, always with regard to the wellbeing and interest (including their views, beliefs and wishes) of the person concerned. In addition, where practicable, they are expected to meet the person in private. Where a person has capacity, the advocate should ask their consent to look at their records and to talk to their family, friends, paid carers, and others who can provide information about their needs and wishes, their beliefs and values. Where a person does not have capacity to decide whether an advocate should look at their notes or talk to their family and friends, then the Care Act requires the advocate to consult both the records and the family and others but consulting the family and others only where the advocate considers this is appropriate and, in the person's, best interests. The Care Act allows advocates ability to access and to copy records where the person is unable to decide whether to give ability themselves. This mirrors the powers of an Independent Mental Capacity Advocate.

Acting as an advocate for a person who has substantial difficulty in engaging with a SAR is a responsible position. It includes:

- Assisting a person to understand the SAR process. This requires advocates to understand the SAR policy and toolkit. It may involve advocates spending considerable time with the individual, considering their communications needs, their wishes and feelings and their life story, and using all this to assist the person to be involved and where possible to make decisions.

- Assisting a person to communicate their views, wishes and feelings to those involved in the review.

Appendix Six – SAR Quality Assurance Framework

ESAB SAR Quality Assurance Framework

Introduction

Essex Safeguarding Adults Board (ESAB) has adopted a Safeguarding Adult Review (SAR) quality assurance process, in line with the Social Care Institute of Excellence (SCIE) SAR Quality Markers. This assumes the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountability).

Clarity of purpose

ESAB is clear and transparent, from the outset, that the SAR is a statutory process, with the purpose of organisational learning and improvement, and acknowledges any factors or challenges that complicate this goal. ESAB's approach to the quality assurance of SARs supports and reinforces the focus on learning and improvement action.

The ESAB SAR Committee will carry out the quality assurance function for each SAR, including the overseeing the process, resultant findings, recommendations and produced report.

SAR responsibilities and functions

No	SAR function & accountability	Responsibility
1	Who has ultimate responsibility, including: • decision to commission a SAR, • sign-off of the SAR report • providing transparency and accountability via ESAB and its annual report • seeking assurance of effective responses by agencies and/or Board • raising any national safeguarding issues resulting from SAR's as appropriate	ESAB Independent Chair
2	Who has delegated responsibility for managing the SAR process? Including: • initial information gathering, • ensure SAR referrals and decision making are timely, with meeting minutes clearly noting the reasons for any delay. • Consider each SAR referral and make recommendations to the ESAB Independent Chair as to whether a SAR should be commissioned (or alternative process if applicable). Recommendation to commission a SAR or not, • decision as to whether immediate assurance or escalation is required to address any current risks • scoping the review, • identifying and commissioning reviewers, • agree and publishing the Terms of Reference • ensure that the types of abuse and neglect within cases is identified and specified within each SAR	SAR Committee

	• agree the methodology / model to be used • provide quality assurance and independent challenge • ensure individuals and families are included; establish who the family members are and if one member is acting as a lead contact, ensure this is received in writing and confirmed by other family members in writing. Agree the format and pattern of communication and what will need to be agreed/discussed. Maintain records of the same. • ensure the review is informed through engagement with front line practitioners and managers by Individual Management Reviews or practitioner events, as deemed appropriate. • provide quality assurance of the report, including consideration of the SCIE quality markers • ensure an accessible and anonymised report is produced which is suitable for publication. • ensure reviews are conducted in a timely manner as a standing SAR Committee agenda item. SAR report follow-up actions, including: • publication recommendations and family views • decisions regarding any immediate actions are required in response to findings • provide evidence of recommendation responses • establish effective methods to share the SAR learning and progression of these • Monitor the longer-term sustainability of changes and evaluation of what difference, if any, has been made?	
3	Who provides practical day-to-day support for the review? Including: • receive SAR referrals and collate information regarding the case for presentation to the SAR Committee • update the referrer and relevant agencies about decisions and any future actions • administrative support • project management support • means of access to data • links with staff; commissioned authors and families • liaison with the ESAB Independent Chair	SAR Officer and ESAB team

4	Who conducts the review? • Conduct independent review • Ensure individuals and families are provided the opportunity to participate and contribute • Engage front line practitioners and managers during the review in order to sharing information about the subject of the review and provide feedback on the analysis of the case as it emerges. • Chair Panel meetings (if required) • Produce an Overview Report and Executive Summary	SAR Reviewer/Author
5	Who participates in the review and provides independent strategic leadership? *This may be the same or different roles depending on whether Panel is used* • provide independent challenge • provide relevant organisational context and leadership • ensure individuals and families are included • identify any further information that is required (the SAR Officer can assist to facilitate further information requests to be made, if required) • ensure the review is informed through engagement with front line practitioners and managers • quality assure the report • ensure an accessible report is produced • ensure reviews are conducted in a timely manner	Reviewer(s) SAR Panel members SAR Committee
6	SAR report follow-up actions, including: • SAR report publication decision • decide whether there are any immediate actions required in response to findings • evaluate longer-term sustainability of changes and evaluation of what difference, if any, has been made? • ensuring that report recommendations are achievable	ESAB Board members, with recommendations of SAR Committee

Quality Assurance Considerations

Setting up the SAR

No	Stage	Quality Statement
1	Referral	The case is referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner. *If there has been a delay in submission, seek rationale and ensure this is documented by ESAB*
2	SAR referral consideration -	Factors related to the case AND the local context inform decision making about

	what kind of SAR, if any, should be conducted	whether a SAR mandatory or discretionary review should be conducted, as well as initial thinking about its size/scope. Consideration and recommendations are documented and submitted to the ESAB Independent Chair. Additionally, are there any immediate actions required in response to information received within the SAR referral to improve safeguarding practice?
3	Decision of ESAB Independent Chair	The ESAB Independent Chair will consider the recommendations of the SAR Committee, make a decision, which is documented, and inform the ESAB team. When the decision has been made a proforma letter will be sent out to all agencies involved, from the Chair of the Board, to advise their senior management of the decision.
4	Update referrer and all relevant agencies of the decision	The ESAB team will update the referrer and the team will send out the Chair's decision letter to all relevant agencies and keep agencies up to date regarding any future actions or requirements.
5	*Making safeguarding personal* - Informing the individuals and/or families and inviting participation	The purpose, function and scoping period of the Safeguarding Adult Review will be discussed with the subject of the Review and or their family members who have consented to participate and whom the SAR Sub-Group or Panel have identified. Any such communication will be managed with compassion and respect for the living, and the dead. All communications with individuals and/or families, will be documented, and Independent Authors must copy the Safeguarding Review Officer into all email communications.
6	Clarity of Purpose	ESAB is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory process, with the purpose of organisational learning and improvement, and is not about apportioning blame. Any factors that complicate this goal which are identified should be notified to the SAR Officer, so that these can be acknowledged.
7	SAR Author commissioning	The personal specification of the SAR Author covers all or most of the necessary areas of expertise.
8	Type of review	Decisions about the precise form and focus of any review take into account a range of case and contextual factors, in order to make the SAR proportionate to the potential for learning and improvement. A statutory review or discretionary review may be commissioned.
9	Terms of Reference	The TOR are agreed by the SAR Committee in order to set out the Key Lines of Enquiry (KLOE) to maximise learning. Decisions are made with input from the ESAB Independent Chair, SAR Committee and Panel Members and in conjunction with reviewers. Terms of reference should always include consideration of how race, culture, ethnicity; sexuality and other protected characteristics (as codified by the Equality Act 2010) may have impacted on the individual's life; case management and discriminatory disadvantage.

Conducting the SAR

No	Stage	Quality Statement
10	Governance	The Safeguarding Adult Review achieves the requirement for independence AND ownership of the findings by the Safeguarding Adults Board and member agencies • Including IMR/Serious Incident investigation (SI) independence • Recommendations are approved by SAR Committee and ESAB
11	Management of the process	The Safeguarding Adult Review (SAR) is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources. • *Any challenges are reported to and considered by the SAR Committee and any decisions are documented.*

12	Parallel processes	Where there are parallel processes, the SAR is managed to avoid as much as possible: duplication of effort; prejudice to criminal trials; and unnecessary delay and confusion to all parties, including staff, the person, relevant family member and agencies including the Coroner's Office.
13	Assembling information	The Safeguarding Adult Review (SAR) gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors. Any challenges in assembling information is shared with the SAR Committee.
14	Practitioner involvement	The review is informed through engagement with front line practitioners and managers. The SAR process enables practitioners and managers to have a constructive experience of taking part in the review.
15	Making safeguarding personal – involving the individuals and/or families	The Safeguarding Adult Review (SAR) is informed by the person and relevant family and network members' knowledge and experiences regarding the period under review. They are involved in aspects of the SAR as determined at the outset of the review. *Advocacy services are considered and utilised as appropriate to ensure the voice of the individual is heard.*
16	Analysis	The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on the routine challenges and constraints to practitioner efforts to safeguard adults.

Outputs, outcomes, and impact of the SAR

No	Stage	Quality Statement
17	The Report	The report identifies clearly and succinctly: reason why the SAR is taking place; methodology used; case and system findings; good and poor practice; reflective and thematic analyses of the same; conclusions; recommendations and references. Some key test areas are: • Have the TOR and KLOE been fulfilled? • If the subject is alive, can the voice of the adult be heard, and or have family views been represented? If not can further remedial action be taken to achieve this? • Has the following been examined: how and why events occurred; how and if information was shared; how decisions were made; what was the impact of actions that were taken or not; would different decisions/actions have led to a different course of events, avoiding hindsight bias; and does the report consider by agency, what happened, systems failures and missed opportunities? • Has information been analysed to identify what needs to happen to either improve practice or prevent such circumstances happening again? • Has good practice been identified and evidenced? • Is the report both comprehensive and succinct? Has it drawn out the main lateral and cross cutting themes e.g., deploying MCA / risk assessment and management /recording/communications/sharing information/lawful compliance/multi-agency working? • Does the report include consideration of the recommendations already made by agencies? (if there are a large amount, they should be included in an Appendix but not repeated) • Are the recommendations specific, measurable, achievable, realistic and outcome focused i.e., what does the organisation/Board need to

		do? • Is the Overview report presented in accordance with commissioning instructions? • Is the evidence presented, unique to the particular case? • Has learning from other SARs/relevant research/ public enquiries been considered? • Has legal compliance been met and relevant guidance considered? • Are national recommendations required? If so, have they been attributed to ESAB's Independent Chair to 'contact and advise' the national body?
18	Recommendations – improvement action	The SAR Author enables robust, informed discussion and agreement by agencies of what action should be taken in response to the SAR report and outcomes must: • Identify the agency(s) who are responsible for deploying particular recommendations • Identify national, local, or regional recommendations and how best to address them? • Ensure recommendations are SMART and achievable, usually enabled by confirmation in advance from agencies.
19	Making Safeguarding Personal – sharing the findings with the individuals and/or families	The SAR draft report is shared with the individual and/or families to: • check accuracy of their participation/information provided • to ensure awareness of Board aim for publication and to ascertain any significant dates/anniversaries to be considered • to invite participation in adoption of a pseudonym for the adult • to seek feedback regarding their involvement in the SAR process
20	Review of the SAR report and recommendations – SAR Committee	The report is considered by the SAR Committee, who will consider elements detailed within sections 17 & 18. The quality assurance task of the SAR Committee should be adequately distinct from the review itself, so as to avoid duplication of effort. The SAR Committee will either recommend further remedial work to be undertaken or submit a recommendation to the ESAB Independent Chair, that the report progresses to the Board. All decisions will be documented within meeting minutes. Additional tasks are: • Proof reading • Identification of any necessary amendments • Identification of any immediate actions required in response to findings • Implications for ESAB's business plan • Checking methodology used • Establishing measures to ensure recommendations are complied with

		• Formulation of an Action Plan and associated Action Log
21	Return to SAR Author for any necessary amendments	If required. Then to be returned to the SAR Committee for approval.
22	Publication considerations	Publication of the SAR report (or Executive Summary) will be considered by the SAR Committee, considering: • Views of the person, their family or other important networks • Views of SAR Committee members • Anonymisation • Benefits of publication in relation to sharing the findings widely • Accessibility of the report • Nomination to the National SAR Library • Any other relevant considerations
23	Submission to ESAB Independent Chair	The Independent Chair will review the SAR report before submission to ESAB and appropriate feedback will be shared with the SAR Officer. The Independent Chair's comments must be adequately addressed by the SAR Panel.
24	Approval of the SAR report by ESAB	The Board, who will consider the report and the recommendation from the SAR Committee, as well as the views of the person, their family and decide if: • The report meets the KLOE; evidence system and case findings; a reflective and thematic analysis is present; a clear methodology is in place; deductive conclusions advise achievable recommendations and making safeguarding personal runs throughout. • The SAR will be published, in accordance with Section 14.166 Care Act 2014, unless there are compelling reasons not to do so (approved by ESAB). Should neither the Overview Report nor Executive Summary be published, there must be a very clear rationale as to why e.g., if young siblings could be affected. • The review has been conducted in a timely manner and to consider implications for future SAR commissioning • Organisational defensiveness can be best managed and or addressed?
25	Making safeguarding personal – sharing the decisions of the Board with the individuals and/or families	The decisions made by the Safeguarding Adult Board are shared with the person and those who have participated (but NOT with any external lawyers), in relation to: • Whether the report has been approved • Whether the report will be published • What name will the report adopt
26	Implementation and improvement action	The SAR Committee enables robust and timely implementation, review and conclusion of SAR recommendations and accompanying action plans.
27	Learning and development	The SAR Committee will consider how best to share the learning from the SAR and make recommendations to the Board. In addition, the SAR Committee will share the findings of the SAR with the Learning and Development Committee and consider how best to disseminate the learning widely to achieve long term sustainability for practice

		improvement, as well as evaluation of what difference has been achieved.
28	Evaluation	The outcomes of the SAR are subject of evaluation, via: • Regular reporting to ESAB of the outcomes of commissioned SAR's • ESAB Annual Report requirements • ESAB Annual SAR Thematic Reviews • Analysis of the sustainable learning and differences evidenced by agency practice