Safeguarding Adult Review Process Guidance

Essex Safeguarding Adults Board

Version 1 (May 2025)

Essex Safeguarding Adults Board

THURROCK SAFEGUARDING ADULTS

Document Control Sheet

Title:	ESAB Safeguarding Adult Review (SAR) Process
Purpose:	To provide an overview of the SAR process for ESAB
Type:	Process Guidance
Target Audience:	Anyone who may be requested to participate in the SAR process and or may need to raise a SAR referral
Date approved: **Review Date:**	May 2025 April 2027
This replaces:	ESAB Safeguarding Adult Review Process - January 2022
Leads / Authors:	Michala Jury - ESAB Board Manager James Butler - ESAB SAR Officer

Contents:

1. Introduction

1.1 Section 44 of the Care Act 2014[1] and associated statutory guidance require Safeguarding Adults Boards (SAB) to conduct Safeguarding Adults Reviews (SARs) in certain circumstances and permits the SAB to arrange them in other circumstances. The Act requires SAB member agencies to cooperate with and contribute to the carrying out of a SAR.

1.2 Members of the Safeguarding Adults Board and other agencies with relevant 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[2] also enables the Safeguarding Adults Board (SABs) to request relevant information from anyone, in order to support the SAB in undertaking a SAR.

1.3 SABs need locally agreed processes for commissioning and learning from SARs. No single review model will be applicable for all cases: review methodology should be determined by the circumstances of each case[3].

1.4 This process sets out:

- the criteria for when Essex Safeguarding Adults Board (ESAB) must or may commission a SAR
- the processes for requesting and commissioning a SAR
- an enhanced menu of options for conducting SARs and detail of how to implement each option
- a decision tree flowchart for selecting a SAR methodology appropriate to the case under review
- how subjects of the SAR, adults at risk, their families and staff involved will be supported in SARs
- how learning from SARs and from other SARs nationally will be acted on in Essex
- templates for letters, terms of reference and reports.

1.5 It is anticipated that, in complementing national and regional guidance, the SAR framework will:

- ensure local processes comply with legal requirements and best practice, incorporating the SAR Quality Standards that have been developed by ESAB
- enable a consistent approach to SAR decision-making and practice
- guide ESAB and local agencies involved; and
- set out how effective SARs serve the public interest and encourage learning.

2. Criteria of Safeguarding Adult Reviews (SARs) in Essex

[1] Section 44 - Care Act Guidance. https://www.legislation.gov.uk/ukpga/2014/23/section/44
[2] Section 45 - Care Act Guidance. https://www.legislation.gov.uk/ukpga/2014/23/section/45
[3] "The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm."
Care and Support Statutory Guidance (DH: 2010) paragraph 14.164

2.1 The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

2.2 **A SAR must always be conducted** when a case meets the criteria as set out in Section 44 of the Care Act 2024. A SAR can be undertaken under either the Mandatory duty, or the Discretionary power, given to SABs by the Act:

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

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

a) There is reasonable cause for concern about how 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' where, 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.

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

A SAB may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support (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.

2.3 A discretionary SAR should only be commissioned when it is clear that there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future. (Section 44 (4) Care Act)

2.4 Some examples of appropriate cases for a discretionary SAR may include:

- Serious incidents that do not meet the criteria for a Mandatory SAR but that ESAB wants to review the case to identify learning
- A case featuring repetitive or new issues which the SAB wants to review in order to proactively identify areas of practice or issues to prevent serious abuse or neglect occurring
- A case featuring good practice in how agencies worked together to safeguard an adult, from which learning can be identified and applied to improve practice and outcomes for adults
- Was there a “near miss”
- Does the case indicate that there may be failings in how the adult safeguarding multi-agency policies and procedures function, leading to serious concerns about how professionals/ services work together
- Did the system not recognise/share evidence of risk of significant harm to an adult (or recognise/share it late)
- Is there evidence that system conditions lead to poor multi-agency working or communication
- Does that case involve serious or systemic organisational abuse and multiple alleged persons to have caused harm, from which learning could be transferred to other organisations to prevent such abuse or neglect in the future
- Could the case potentially yield systems learning around how agencies work together to prevent and reduce abuse and neglect that would help us do things differently in the future
- Would a SAR enable the SAB to identify areas of practice to prevent serious abuse or neglect happening
- Does intelligence from other quality assurance and feedback sources (e.g. audits/complaints) suggest that the kind of issue in this case is new/complex/ repetitive and conducting a SAR would therefore be beneficial
- Has this happened before (in Essex or elsewhere) and was a SAR commissioned
- Has the learning from any previous SARs been implemented or is there new learning to be identified
- Is there adverse media interest or serious public concern
- Is there evidence of sufficient good practice that could be mainstreamed across the partnership to the benefit of adults and their families
- Considering links to LeDeR process. LeDeR is a service improvement programme for people with a learning disability and autistic people. A SAR always takes priority due to its statutory status. Within the agreed methodology of a LeDeR, the reviewer is expected to contact the SAR lead and agree if the LeDeR can proceed or to be put on hold which is often the case (pending the outcome of the SAR)

2.5 Where the person is alive: is enough known about their experience to explore the impact of the abuse and/or neglect in a person-centred way, which may include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness.

2.6 There is no requirement for a case to have gone through a Section 42 Safeguarding

Adults Enquiry or any other review process, before it can be referred for a SAR. A SAR referral should be made as soon as it appears the criteria for a review might be met.

2.7 In instances where there is a disagreement in the decision making for SARs, submission can be made to ESAB's Independent Chair, who retains ultimate responsibility for deciding when to commission a SAR, as stipulated by ESAB Quality Standard – 1.

3. REQUESTING A SAFEGUARDING ADULTS REVIEW

3.1 For the purposes of this policy, the information relates to Essex and not the unitary local authorities of Southend and Thurrock (you will need to seek alternative guidance if your possible SAR has been undertaken in those areas)

3.2 Any agency, professional, volunteer or individual can use the process to request a SAR on a case believed to fit the criteria listed in section 2 above.
A flowchart of the process is available at Appendix 1

3.3 Where a professional or volunteer working for an agency is requesting a SAR, the request should first go through their organisation's appropriate management structure.

3.4 If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. NHS Patient Safety Incident Response Framework (PSIRF), Domestic Abuse Related Death Reviews (DARDR) & LeDeR Process') this should take place as a matter of priority. Internal governance processes and multi- agency reviews are not mutually exclusive, so a request for a SAR can be made at the same time if appropriate.

3.5 If a SAR referral is required a copy of the referral form should be requested via ESAB@essex.gov.uk
A sample of the form can be seen in Appendix 2, but this **MUST NOT** be used to forward a referral as it is subject to change.

3.6 Requests should then be submitted securely to ESAB@essex.gov.uk. Confirmation of receipt of the request is sent by email to the requestor. Subsequent contact will take place once the relevant ESAB officer has commenced the process and decision have been made (This will be dependent upon workloads).

3.7 Following review of the SAR referral submission, ESAB reserve the right to return the referral and ask for more information.

3.8 On receiving a request the ESAB SAR Officer will initiate the ESAB Rapid Review process by sending out a scoping document to all agencies. All documents are returned securely and a Rapid Review report is prepared and shared with the SAR Subcommittee prior to the meeting at which the case will be presented. The referrer will be invited to attend the meeting to participate in the discussion.

3.9 Once the information is received, the Standing SAR Subcommittee meets to

undertake decision making, in line with the SAR criteria and undertake further information gathering if required. Once a decision has been made, a discussion record and Decision-Making tool documentation will be completed.

3.10 If appropriate, the lawfulness of the decision making will be checked.

3.11 The Independent Chair of the SAB will review and scrutinise the decision of the SAR Subcommittee via review of the Decision-Making tool, discussion record and Rapid Review report. Should the Independent Chair disagree with the Subcommittee's decision, feedback will be provided, and the Subcommittee will discuss this feedback and consider how to respond. In instances where there is a disagreement in the decision making for SARs, submission can be made to ESAB's Independent Chair, who retains ultimate responsibility for deciding when to commission a SAR.

3.12 Once the final decision from the Independent Chair has been made, the ESAB SAR Officer will write to all relevant agencies to notify them of the decision to commission a SAR and the methodology to be used. Appropriate senior managers within those organisations should then make the necessary arrangements for participation in the SAR, e.g. immediate securing of files and records, nominating a representative for a SAR panel etc. This includes all regulatory and commissioning bodies on behalf of the Independent Chair.

3.13 Where the referrer is dissatisfied with the outcome, they should notify the Independent Chair of ESAB in writing, who will discuss and review (if necessary) the decision with the referrer and the SAR Subcommittee and come to a final decision.

4 MAKING DECISIONS ON SAR REFERRALS

4.1 In deciding whether a SAR should be conducted, the SAR Subcommittee must first consider whether there is a statutory obligation to undertake a SAR – whether under the Mandatory duty or the Discretionary power, using the criteria outlined in paragraph 2.2 of this document. A SAR must be commissioned if the Mandatory criteria are met.

4.2 In deciding whether a SAR should be conducted, it should be considered if there is any cause for concern about the quality of safeguarding practice, paying particular attention to the principles of Making Safeguarding Personal.

4.3 In cases other than those involving a Mandatory duty, the SAR Subcommittee should carefully consider whether commissioning a SAR under the Discretionary power would be a valuable exercise:

i.e. whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focused on those cases that will yield the greatest learning and practice development. (see item 2.4 for considerations to be taken into account)

4.4 The SAR Subcommittee should also consider whether another review or learning process has already taken place that will identify and share lessons to be learned, or

which ESAB could potentially feed into to avoid duplication (e.g. Domestic Abuse Related Death Reviews or the Health based Patient Safety Incident Response Framework) and provide clarity about any governance issues if other processes are involved.

4.6 If, in deciding to commission a SAR the SAR Subcommittee cannot reach a consensus, the final decision will rest with the Independent Chair of ESAB.

5 RELATIONSHIPS TO PARALLEL PROCESSES

5.1 When a case meets the criteria for a SAR, the ESAB SAR Subcommittee will seek to identify at the outset what other reviews and processes are taking place or envisaged in relation to the same events, such as:

- Child Safeguarding Practice Review
- Police investigation/criminal charges
- Health based Patient Safety Incident Response Framework
- Domestic Abuse Related Death Reviews
- Coroner's inquest

5.2 Early contact will be made with the Chair/lead reviewer of any parallel process in order to:

- determine how the reviews can be effectively managed to maximise learning for individuals and organisation
- avoid duplication for families and professionals.

Consideration will also be given to:

- Whether the actions of all agencies and all aspects of the case could be effectively covered by one of the other reviews taking place
- Whether it would be appropriate for related reviews to be chaired by the same person
- Whether some aspects of related reviews could be commissioned or undertaken jointly
- Ensure that the terms of reference for related reviews effectively cover all aspects of the case
- How to engage with adults, families and/or advocates to enable involvement and contribution to reviews, and how their expectations can be managed appropriately and sensitively.

6 MAKING A DECISION ON SAR METHODOLOGY

6.1 Once the SAR Subcommittee have agreed to commission a SAR, they must decide on the most appropriate methodology to use. This must be appropriate and proportionate to the case under review. The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

- **SAR Author/chair** – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience that show:

- Strong leadership and ability to motivate others
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
- Good analytical skills using qualitative data
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge
- Commitment to/ promotion of open and reflective learning cultures.

- **SAR Panel** – to scrutinise information submitted for the review. The panel size should be proportionate to the nature and complexity of the review but should comprise a minimum of three members in addition to a chair with a level of independence from the case under review.
  (This may differ slightly, dependant upon the methodology used for a review)
- **Terms of reference** – published and openly available.
- **Early discussions with the adult and their family, carers and friends** – to agree to what extent and how they would like to be involved in the SAR, and to manage expectations. This should also include access to independent advocacy if required.
- **Appropriate involvement of professionals and organisations who were working with the adult** – to enable them to contribute their perspective of a case without fear of being blamed for actions they took in good faith.
- **SAR report and recommendations**

6.2 A decision tree and a menu of options for SAR methodologies that have been developed by ESAB is provided in sections 8.5 & 8.8 below. The methodology selected must offer the most effective learning and involvement of key staff/ family weighed against the cost, resources and length of time required to conduct the review.

6.3 The following should be considered in selecting a SAR methodology:

- Is the case complex, involving multiple abuse types and/or victims
- Is significant public interest in the review anticipated
- Is large-scale staff/family involvement wanted/appropriate
- Are any criminal proceedings ongoing that staff are witnesses in and could the SAR methodology impact on them
- Is the type of review being suggested 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
- Can value for money be demonstrated

6.4 In addition to selecting a SAR methodology, the ESAB SAR Officer and SAR Subcommittee partners must also decide:

- Which agencies (including legal, and CQC as required) should be asked to participate in the SAR panel.
- Level of independence from the case required of panel members
- Whether agencies are required to secure their files/records.
- Level of independence required of the SAR chair (e.g. representative from another agency, external consultant etc.)
- Consideration of how learning will be disseminated and embedded

- The required output from the SAR (e.g. a report).
- Whether an independent author is required, and level of independence.
- Provide clarity over governance issues if there are links to other reviews

7 MENU OPTIONS FOR THE SAR METHODOLOGY

7.2 When considering a SAR, the ESAB SAR Subcommittee review five different types of SAR methodology options to help identify the learning for professionals. These are:

1. Option A – Traditional SAR
2. Option B – System Review
3. Option C – Significant Event Analysis
4. Option D – Tabletop/Hybrid
   (This is a bespoke option covering aspects from options in this list of C&E)
5. Option E - Appreciative Inquiry

See table below on page 12 for further explanations on these options.

8 SAR METHODOLOGY GUIDANCE

8.2 When is a SAR referral received in Essex, the Rapid Review process (previously called consideration) is undertaken to determine if a S44 SAR (Mandatory or discretionary) should be completed.

8.3 The Rapid Review aims to be completed within:

- One month of receipt of the SAR referrals (This may be delayed dependent upon the number of SAR referrals being dealt with at any one time)
- Standardised processes and templates
- Supported by remote meetings does not require any face-to- face contact
- No agency management reports
- Integrated chronology (may be considered)
- Looks at what's happened & reflects on gaps to identify questions for the SAB

8.4 Once a decision for a S44 SAR has taken place the SAR subcommittee will consider which methodology of SAR is most appropriate following the table below and the decision tree flowchart at 8.8 below.

8.4 To ensure that SARs are undertaken at a value for money cost for partners in Essex, ESAB has adopted a three-tier payment system, the costs for each level are considered by the type these being:

ESAB SAR levels	Cost range
Level 1	£6000 - £7500
Level 2	£4000 - £6000
Level 3	£2000 - £4000

8.5 Methodology Table

Type of review	Methodology	Pros	Cons	Cost
Option A: Traditional SAR (IMR or summary of involvement, Chronology/Review panel)	SAR considered to be complex and requiring full analysis with documentation, panel meeting s and practitioners and/or learning events	▪ Familiar process: considered robust/objective ▪ Strong level of independence/scrutiny ▪ Assurance: tried & tested approach ▪ Useful for high-profile/serious incidents ▪ Methodology reflects that of SAR, CSPR or DARDRs ▪ Action plan: clear practice & system changes	▪ Bureaucratic ▪ Not light touch ▪ May delay implementation of learning ▪ Costs may not justify outcomes ▪ Can be perceived as attributing blame ▪ Frontline staff disengaged from process & learning	Level 1 £6000 - £7500
Option B: Systems Review/Thematic Review	▪ Team/investigator led ▪ Staff/Adult/family involved via interviews ▪ No agency management reports ▪ Integrated chronology ▪ Looks at what's happened & reflects on gaps to identify areas for change ▪ System Identification of Trends and themes ▪ Comparators when analysis has taken place ▪ Evidence based outcomes	▪ Process of reflection ▪ Reduced burden on individual agencies ▪ Team of Reviewers provide balanced view ▪ Fits well with criminal proceedings ▪ Enables identification of multiple causes/contributory factors ▪ Focuses on areas with potential to cause future incidents ▪ Based on academic research & review ▪ RCA tried and tested in healthcare sector	▪ Analysis falls on small team/individual ▪ May result in reduced single agency ownership of learning/actions ▪ Staff/family involvement limited ▪ Potential for data inconsistency/conflict ▪ Unfamiliar process to most ▪ Trained reviewers not widely available ▪ Not light touch More suited to single events/incidents not complex issues	Level 1 £6000 - £7500 or 2 £4000 - £6000
Option C: Significant Event Analysis	This approach brings managers and/or practitioners together to consider significant events within a case and together analyse what went well and what could have been done differently,	▪ Light touch & cost-effective ▪ Produces learning quickly ▪ Contribution of learning from staff ▪ Shared ownership of learning	▪ Not designed for complex cases ▪ Lack of independent review team may undermine transparency/validity	Level 2 £4000 - £6000

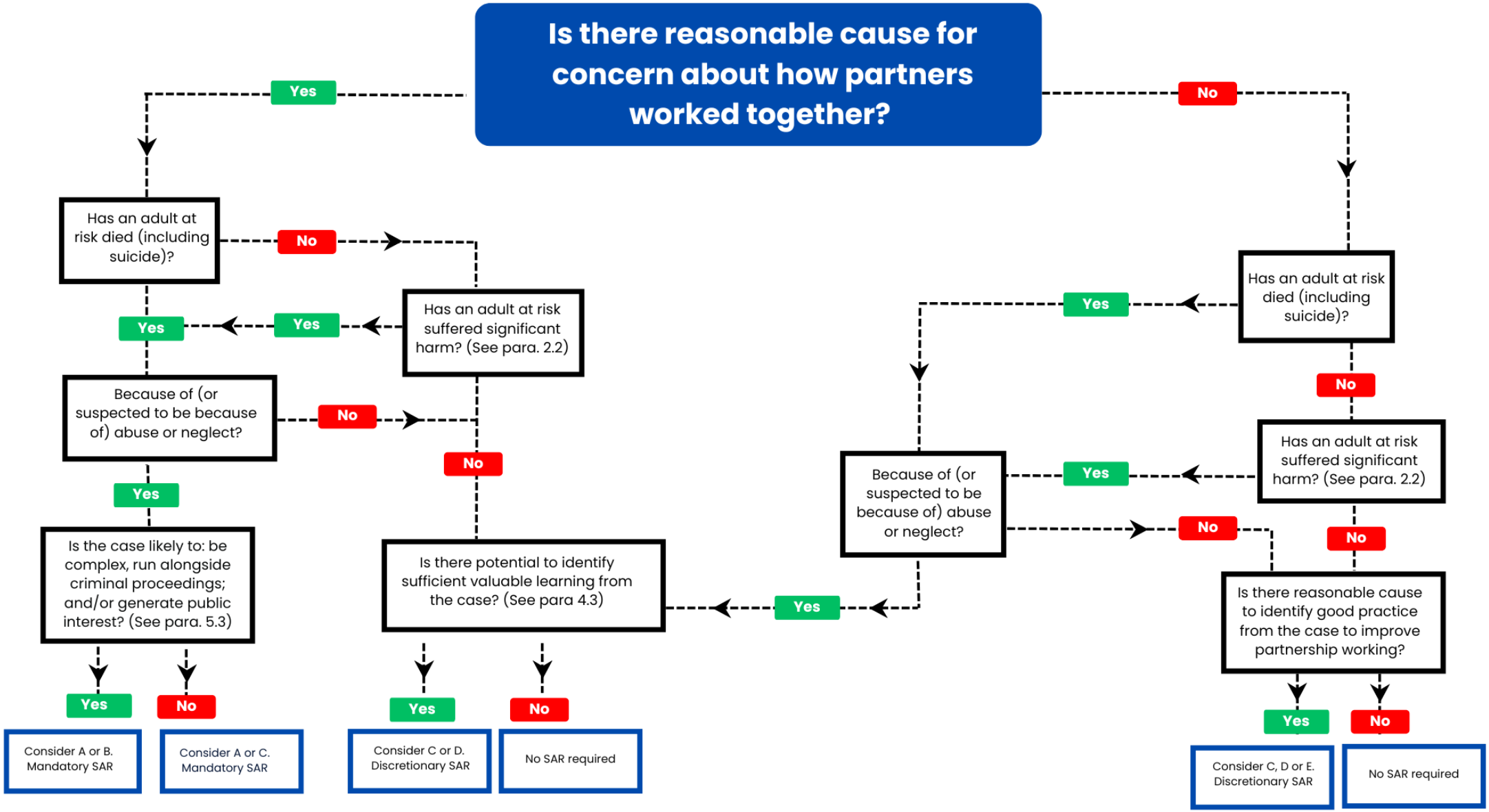
	producing a reports with action plan/recommendations for learning and development. ▪ Group led via Panel (no more than 2 meetings with panel), with facilitator ▪ Staff/adult/family involved via Panel ▪ Chronological information based obtained by scoping/rapid review documents ▪ No single agency management reports ▪ One/two workshop(s) ▪ Aims to understand what happened & why/encourage reflection & change	▪ Reduced burden on individual agencies to produce management reports ▪ Suits less complex/high-profile cases ▪ Trained reviewers not required ▪ Familiar to health colleagues	▪ Speed may reduce opportunities for consideration ▪ Not designed to involve family ▪ May not suit where criminal proceedings are ongoing	
Option D: Tabletop/Hybrid model	Utilisation of learning from other types of reviews e.g. s42 Safeguarding Enquiries, Patient Safety Incident Investigation (PSII), internal investigations or reviews. ▪ Group lead process – 1/2 meetings/practitioner events ▪ Chronological information based obtained by scoping/rapid review documents ▪ Details come from the consideration reports, rapid review documents and other available review reports and then discussions at practitioner events ▪ Aims to find out what went wrong and explore what should have happened	▪ quicker process ▪ Contribution of learning from frontline and managers ▪ Ownership of learning ▪ Family can be involved ▪ Effective for identifying good practice ▪ Can focus on one area of concern or several ▪ Prevents duplication from outcomes already achieved	▪ Not designed for complex cases ▪ Speed of review may reduce opportunities for consideration (not everyone will be happy with clear focus) ▪ Not suitable for Criminal proceedings ▪ No panel to review/debate the reports – emphasis for QA will fall to the SAR Subcommittee	Level 2 £4000 - £6000 or 3 £2000 - £4000

	▪ Aims to highlight any blockages in the system and encourage reflection and change ▪ Aims to identify good practice and how this can be replicated			
Option E: Appreciative inquiry	Utilisation of learning from other reviews (if these have taken place) to address the issue Workshop event to look at reviews ▪ practitioner group led, with facilitator ▪ Staff involved via practitioner group; Adult/ family involved via meeting ▪ Chronological information based obtained by scoping/rapid review documents ▪ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often	▪ Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days in relation to practitioners events ▪ Staff who worked on the case are fully involved ▪ Shared ownership of learning ▪ Effective model for good practice cases ▪ Some trained facilitators available ▪ Well-researched and reviewed academic model ▪ Model understood fairly widely	▪ Not designed to cope with 'poor' practice/ systems 'failure' cases ▪ Adult/ family only involved via a meeting ▪ Speed of review may reduce opportunities for consideration ▪ Model not well developed or tested in safeguarding ▪ Minimal guidance available	Level 3 £2000 - £4000

8.6 The above table are examples of review methodologies which ESAB SAR Subcommittee consider when agreeing for a SAR to be completed. This is not an exhaustive list, and the SAR Subcommittee may wish to use its collective expertise to recommend an alternative approach, if and where appropriate.

8.7 Regardless of which methodology is used, contributing agencies need to be mindful that there may be public scrutiny of information provided by agencies to the SAR and, in particular, HM Coroner may request information. All agencies should therefore ensure their senior managers approve any written submissions to a SAR, and where they consider it appropriate, seek legal advice prior to submission.

8.8 Methodology tree flowchart



9 CONDUCTING THE SAFEGAURDING ADULTS REVIEW

9.1 If the SAR request is agreed, the ESAB Board manager and ESAB SAR Officer will identify and commission an appropriate reviewer/author to chair the SAR panel and lead the review, briefing them on the agreed methodology, any key lines of enquiry or Terms of Reference discussed by the SAR Subcommittee and required timescales.

9.2 A multi-agency SAR Panel will be set up in line with the methodology and any requirements set by the SAR Subcommittee (this will be dependant on the type of methodology used and discussed with the lead reviewer/author).

9.3 The ESAB SAR Officer, in supporting the SAR panel chair will:

- Set SAR panel meeting dates and agendas as required.
- Invite all nominated representatives from relevant agencies to SAR panel meetings.
- Notify ESAB Board officers of any administrative/resourcing arrangements that are missing.
- Liaise with the police as required.
- Liaise with the coroner as required
- Arrange early discussions with the adult subject to the SAR (if alive) or respective family/representatives and arrange any support they require to participate.
- Initiate the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice.
- Request any data/evidence/reports from partner agencies as required.

10. ADULT/ FAMILY INVOLVEMENT AND INDEPENDENT ADVOCACY

10.1 This section must be read in conjunction with Section 68[4] of the Care Act and associated statutory guidance, and in conjunction with ESAB SAR Quality Standards.

10.2 Adults and/or families should be invited and supported to contribute to SARs[5] if they wish to do so, so that their wishes, feelings, and needs are placed at the heart of the review.

10.3 The SAR Panel Chair, SAB Manager, SAR Officer must attempt to make contact with the adult (s), their family and/ or representatives early on to establish:

- Why and how a SAR will be undertaken into their (family member's) case.
- How they would like to be involved – e.g. views contributed via telephone conversation or interview.
- Any support or adjustments they would need to facilitate their involvement.

[4] Section 68 Care Act Guidance. https://www.legislation.gov.uk/ukpga/2014/23/notes/division/5/1/14/2
[5] See paragraph 14.136 of the Care & Support guidance – chapter 14. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

- Their initial views, wishes, concerns, and any answers/outcomes they would like to achieve from the SAR.
- Reasonable and appropriate support and adjustments should be made by ESAB to enable the adult(s), their family and/or representatives to participate in the SAR. This may include, but is not limited to:
  - ❖ Easy read, large print and/ or translated materials.
  - ❖ Access to an interpreter.
  - ❖ Support from a chosen chaperone or representative.
  - ❖ Longer meeting times
  - ❖ Pre-meeting briefings and post-meeting de-briefs.
  - ❖ Access to an independent advocate.

10.4 If there is no appropriate person to support and represent the adult(s), then ESAB must arrange for an independent advocate (under Section 68[6] of the Care Act). Arrangements should be made in line with Essex County Council standard policy and procedures for arranging advocacy.

10.5 Alternatively, if the relevant criteria are met, appropriate partners can make arrangements for an independent mental capacity advocate (IMCA) or an independent mental health advocate (IMHA) to support and represent the adult(s). If an independent advocate, IMCA or IMHA has already been arranged for the adult (s) e.g. during assessment and care support planning or for a safeguarding enquiry, then the same advocate should continue to be used.

10.6 It is for the SAR panel to form a judgement on a case-by-case basis about whether the adult(s) has "substantial difficulty" in being involved in the SAR process[7] and about who can act as an appropriate person[8]

11. STAFF/PROFESSIONALS INVOLVEMENT

11.1 As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers, and their line managers. It should be made clear that the review process can be lengthy.

11.2 It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and

[6] Section 68 Care Act Guidance. https://www.legislation.gov.uk/ukpga/2014/23/notes/division/5/1/14/2
[7] See paragraph 7.9 of the Care & Support guidance - chapter 7. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#Chapter7
[8] See paragraph 7.40 of the Care & Support guidance - chapter 7. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#Chapter7

practitioners involved in a SAR to “tell it like it is” without fear of retribution, so that real learning and improvement can happen.

11.3 Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offered support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

12. PROFESSIONAL CONDUCT ISSUES ARISING

12.1 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, and there are separate formal processes to address these. It is not within the SAR remit to deal with these. (ESAB - SAR Quality Standard - 6)

12.2 Where concerns about an individual’s practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

13. SAR REPORTS

13.1 The required output of a SAR (whether a report is needed and/or independent authorship) is to be set out in the SAR Terms of Reference as agreed by the SAR subcommittee and the ESAB Independent Chair. It is anticipated that for mandatory SARs and some discretionary SARs a report will be required (the size of which is determinant to the type of methodology agreed.

13.2 The SAR panel chair/author must ensure that there is sufficient analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR panel should form the basis of any SAR report, to be produced by the nominated author.

13.3 The SAR panel should receive and agree the draft report before it is presented to the SAR Subcommittee and then subsequently ratified by ESAB so that individuals are satisfied that the panel’s analysis and conclusions have been fully and fairly represented.

13.4 The adult(s) and/or family representatives should also be given the opportunity to discuss the SAR report and conclusions and their experience of the process.

13.5 ESAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the ESAB website or alternative ways of learning (briefs or video etc). Any reports or learning to be published must be fully anonymised.

13.6 The Board Manager and ESAB SAR Officer will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with ESAB's information sharing agreement, the Data Protection Act and other legal requirements.

14. QUALITY ASSURANCE OF THE SAR

14.1 Quality assurance is embedded throughout the SAR process, from commissioning through to ESAB scrutiny of the report and implementation of recommendations. Quality assurance is also built into the SAR methodology options set out in this framework.

14.2 In each model it is imperative that SAR panel members avoid agency defensiveness and arguments about minute detail of what happened. The following arrangements will help to avoid/ minimise this:

- Commissioning the most appropriate SAR methodology for the case
- Commissioning a suitably skilled, experienced and independent SAR lead or chair to facilitate the review and analysis.
- Independence of SAR panel members from the case under review.
- A focus in each model on seeking out causal factors and systems learning.
- Requirements in the terms of reference for the SAR to take a broad learning approach and to "tell it like it is".

14.3 Finally, the contents of the report presented to the SAB must contain enough of the methodology for the SAB to be able to check, scrutinise and challenge. In doing so, the SAB will gain assurance of the adequacy of the evidence, quality of the analysis and usefulness of the recommendations, but will not duplicate the work already completed in the course of the SAR. (See ESAB SAR Quality Standard - 16)

15. ACTING ON THE RECOMMENDATIONS OF THE SAR

15.1 Following the identification of recommendations from the SAR report completed by the SAR author, members of the SAR Subcommittee and ESAB independent chair will provide their agreement, multi-agency partners (if relevant) will then be requested to identify actions, which should be endorsed at senior level by each organisation to whom it relates linked to the SAR report recommendations which ESAB will monitor. This process may differ slightly dependent upon the individual case.

15.2 The SAB can and may decide not to implement a recommendation(s) if they are deemed not achievable.

15.3 The multi-agency action plan will indicate:

- The actions that are needed.
- Responsibilities for specific actions.
- Timescales for completion of actions.
- The intended outcomes: what will change as a result?
- Mechanisms for monitoring and reviewing intended improvement
- The processes for dissemination of the SAR report or its key findings.

15.4 Individual agencies may also be asked by the SAB to produce their own internal action plans if required.

15.5 Board members of ESAB are responsible for ensuring all actions are completed from their own and the multi-agency action plan and for ensuring that learning from the SAR is embedded within their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.

15.6 ESAB will monitor progress on all recommendations (or delegate to an appropriate Subcommittee) and may commission specific pieces of work to measure the impact. It will also request progress update reports from relevant agencies, until such time that all actions have been completed.

15.7 In line with Schedule 2 of the Care Act[9], ESAB will include findings from any SARs in its annual report, and information on any ongoing SARs.

16. APPLYING LEARNING FROM OTHER SARs

16.1 ESAB is committed to the regular analysis of the themes and learning from nationally high-profile SARs and relevant other SARs as selected by the SAR Subcommittee.

16.2 The SAR Subcommittee has a process for the review of SARs from outside Essex as part of their annual workplan to ensure lessons are identified, disseminated, and embedded:

- The ESAB SAR Officer identifies key themes and learning from SARs outside of Essex, and presents findings from a case to the SAR Subcommittee
- The SAR Subcommittee reviews the themes and learning from other areas context to evaluate learning and identify any areas of improvement for Essex.
- The learning is disseminated to partners via their SAR Subcommittee members for discussion and implementation of any single agency learning, it is also shared via the SET Children/Adults & SETDAB Learning & Development

[9] Schedule 2 – Care Act. https://www.legislation.gov.uk/ukpga/2014/23/schedule/2

Subcommittee, ESAB Quality Subcommittee and the ESAB Prevention & Awareness Subcommittee as appropriate.

- Relevant multi-agency learning and actions identified will be drawn together and presented to the ESAB SAR subcommittee and ESAB meetings for discussion and consideration and actioned distributed across all of the ESAB subcommittee meetings.

16.3 The SAR Subcommittee will do whatever else seems reasonable to facilitate the dissemination and embedding of this learning into practice, for instance, facilitating a learning slot at an ESAB meeting or away day, circulating e- newsletters, incorporating findings into training and workshops for staff etc.

17. SUPPORTING AND RESOURCING SARs

17.1 Section 44(5)[10] of the Care Act requires each member of ESAB to co-operate in and contribute to the carrying out of a SAR, with a view to:

- Identifying the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases.

17.2 Partners are required under Sections 6[11] and 7[12] of the Care Act to:

"cooperate in general in the performing of statutory functions under the Care Act that relate to protecting adults with needs for care and support and/ or carers from abuse and promoting their wellbeing, including SARs."

and

"cooperate when requested in relating to specific cases, such as SARs"

17.3 In addition, Section 45[13] of the Care Act places a duty on all partner organisations to supply information to ESAB (or other specified person) where they are likely to have relevant information that will enable or assist the SAB in exercising its functions – including conducting SARs.

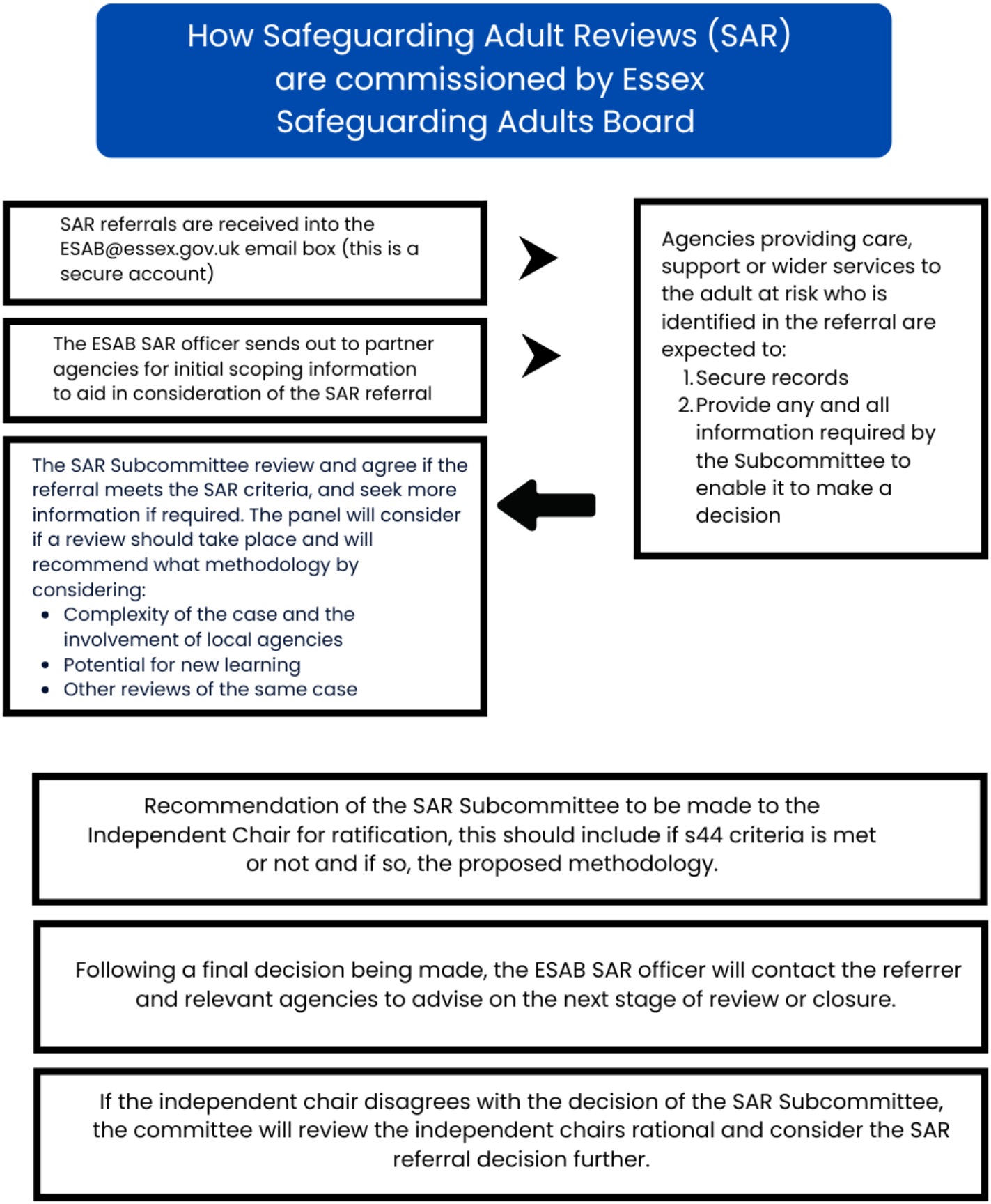
17.4 Resources are needed for undertaking and supporting a SAR. The statutory partners on the ESAB provide a yearly contribution to ESAB budget which ensures that the relevant costs for each SAR can be met. Although it is noted that should such a time come where there is a need for additional resourced to cover this statutory role, an additional ask of resources may be requested in cash or kind, on a shared basis to ensure that the relevant costs for each SAR can be met

17.5 All partners will commit internal resources to the production of evidence for a SAR (e.g. an Independent Management Review (IMR) or interviews/ conversations with relevant staff) as requested by the SAR panel.

17.6 The ESAB SAR Officer will maintain an annual overview of SAR related costs for the SAB, for consideration each year as part of the annual report.

[10] Section 44(5) Care Act. https://www.legislation.gov.uk/ukpga/2014/23/section/44
[11] Section 6 Care Act. https://www.legislation.gov.uk/cy/ukpga/2014/23/section/6
[12] Section 7 Care Act. https://www.legislation.gov.uk/ukpga/2014/23/section/7
[13] Section 45 Care Act. https://www.legislation.gov.uk/ukpga/2014/23/section/45

Appendix 1: How Safeguarding Adult Reviews (SARs) are commissioned by Essex Safeguarding Adults Board



Appendix 2: SAR Referral form (SAMPLE only - DO NOT USE for submitting a referral)

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)

SECTIONS 7A & 7B MUST BE COMPLETED, THE FORM WILL BE RETURNED IF THEY ARE NOT

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:	