Safeguarding Adult Review (SAR) Procedure

A local agreement for requesting and conducting a Safeguarding Adult Review in accordance with section 44 Care Act 2014

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Contents

1. Introduction

1.1 The Care Act 2014 places a statutory duty on Safeguarding Adult Boards to undertake Safeguarding Adult Reviews (SAR).

1.2 This protocol has been developed by the Surrey Safeguarding Adults Board (SSAB) to support the effective identification of and response to SARs within the county in order to ensure the Safeguarding Adults Board is discharging its statutory duty.

1.3 This procedure aims to ensure that there is a consistent approach to the process and practice in undertaking Safeguarding Adult Reviews that follows both statutory guidance and local policy.

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

14.162 Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.163 SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

14.164 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.

2. Purpose

2.1 The purpose of a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an enquiry into how a vulnerable adult died nor is it to apportion blame; but to learn from such situations, and to ensure that any learning is applied to future cases to prevent similar harm occurring again.

2.2 Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

2.3 It will be highly likely that a safeguarding process will have been followed in relation to the circumstances. The SAR is for consideration of the most serious issues and will not be an alternative to a safeguarding enquiry, investigation or process.

2.4 The purpose of conducting a SAR is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard vulnerable adults.
- Review the effectiveness of procedures and their application (both multi-agency and those of individual organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.

- Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.5 It is acknowledged that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these. Undertaking a SAR remains a statutory requirement and where appropriate the SAR will be complemented by other such processes to ensure professionals learn from the case.

3. Criteria for a Safeguarding Adult Review

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

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **and**

(b) condition 1 or 2 is met.

Condition 1 is met if —

(a) the adult has died, **and**

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if —

(a) the adult is still alive, **and**

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.2 The SSAB will only consider cases where the person who has died or come to harm is ordinarily resident in Surrey, as per the Care Act. In practice this means that the SAR sub-group will consider cases where the person is resident within the county at the time of their death/serious incident. Should a person placed by a Surrey CCG or by Surrey County Council in another area be subject of circumstances that would be a SAR, then it would be for the SAB of that locality to oversee and carry out a SAR.

3.3 The SSAB has the flexibility to arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

4. SAR Operating Framework and Governance

4.1 The Surrey Safeguarding Adults Board (SSAB) has the lead responsibility for carrying out a Safeguarding Adult Review (SAR).

4.2 The SSAB has delegated management of this responsibility to one of its subgroups, the Safeguarding Adult Review Sub-Group, chaired by Surrey Police. The Sub-Group membership is made up of the statutory members of the SSAB (the Local Authority, Police and Clinical Commissioning Group), with specific Terms of Reference that are annually reviewed. The sub-group reports to the SSAB.

4.3 The Sub-Group meets on a planned basis throughout the year (every 6 weeks) to review SAR notifications, decide on next steps and to coordinate SARs in progress.

5. Submitting a SAR notification

5.1 Any agency or professional can submit a SAR notification form, in any case where the criteria are met.

5.2 Staff will usually find it helpful to discuss their concerns with their organisation's safeguarding lead prior to making a referral.

5.3 Referrals must be sent via secure email to the SSAB Administrator using the notification form at appendix 1.

6. Deciding to undertake a Safeguarding Adults Review

6.1 Once a notification of a SAR is received, the SSAB Administrator will make the Chair of the SAR sub-group aware and add the notification form to the agenda for the next meeting in order that members of the sub-group can discuss and decide if the criteria are met.

6.2 On occasion, SAR notification forms are submitted to the Board where either:

- the intention was to refer an adult safeguarding concern for consideration by Surrey County Council for an adult safeguarding enquiry; or
- the referral for a SAR is premature as there has not been a process to establish the facts, such as establishing that there has been abuse or neglect. In most instances, this is likely to be established through a s42 Care Act enquiry, but it could also be through other processes such as a Coroner's Inquest.

If a SAR notification is referred and it appears to the staff of Surrey SAB that either of these two conditions may apply, Surrey SAB staff will work with the referrer in order to establish if actions are needed by the referrer, such as referring an adult safeguarding concern to the local authority, before the matter is considered by the Board. Partner organisations are asked to have in place processes for quality assuring SAR notifications before they are referred to the Board in order to avoid such issues arising.

6.3 Agencies who had contact with the adult will be asked to supply additional information in advance of the SAR sub-group meeting in order to inform this decision. This will be done using the template at appendix 2.

6.4 The SAR sub-group will review the notification and supplementary information against the criteria for completing a SAR. The SAR sub-group will make a recommendation to the SSAB Chair who has ultimate responsibility for deciding whether to conduct a SAR.

- If the sub-group agree that a SAR should be instigated, the group will also recommend the methodology for doing so (see section 7).
- The SAR sub-group may recommend not to proceed to a SAR but may request an alternative review (serious incident, DHR, SCR) or request a small-scale audit of agency involvement).
- If the criteria is not met, the sub-group may decide that no further action be taken.

6.5 The Chair of the SAR sub-group will notify the referrer in writing of the decision made by the SSAB. If the decision is not to proceed, the letter will also include the reasons for the decision and clarity on what will happen to the information supplied.

6.6 Once a decision has been made to instigate a SAR, the regulatory body will be notified by the chair of the sub-group if the concern involves a regulated service.

7. SAR Methodology

7.1 The Care and Support Statutory Guidance states that the SAB must identify the most appropriate review that will promote effective learning and encourage action to be taken that will prevent similar incidents happening again.

7.2 There are several methodologies for undertaking SARs and no one model will applicable for all cases, the most appropriate and proportionate method must be agreed by the SAR sub-group.

7.3 Whichever methodology is chosen, the following elements will usually feature:

- Panel Chair
- SAR Panel
- Terms of reference
- Agreed involvement with the family
- Involvement of professionals who were working with the person
- Final report and recommendations

7.4 The decision on the methodology must also take into consideration the cost, resources and length of time required to conduct the review.

8. Conducting a Safeguarding Adults Review

8.1 Once it has been agreed that a SAR should take place the SAR sub-group will identify the agencies which need to be approached to contribute to the review.

8.2 The Chair of the SAR sub-group, will write to the senior officer within each relevant organisation to:

- advise them that their agency's records relating to the adult in question need to be secured with immediate effect,
- request for them to nominate a representative for any SAR Panel that is subsequently convened,
- confirm any other immediate actions required.

8.3 As part of the considerations for commencing a SAR, the sub-group may decide to appoint an independent person to lead the review and chair the panel. They may also decide to appoint an independent report writer to develop the overview report and develop the recommendations. Both roles should be filled by people with sufficient standing and expertise and there must be no conflict of interest.

8.4 The SAR panel with appropriate multi-agency membership will be appointed to work alongside the independent Chair. At their initial meeting the SAR panel will agree:

- The Terms of Reference for the SAR, including the period for which the SAR will focus.
- Which partner agencies should be asked to submit an Individual Management Review (IMR).
- How the adult at risk (where he or she has survived) will be supported and involved in the SAR process.
- How relatives, family or friends will be involved in the SAR and who will act as liaison and support to them (see section 10).
- Arrangements for any on-going support (e.g. legal support, report writer)

8.5 A full list of the roles and responsibilities involved in the SAR process are included at appendix 3.

8.6 The chair of the SAR panel will make a formal request to the agreed agencies for them to complete an individual management review (IMR) detailing their involvement with the adult (appendix 4). Each agency will be provided with the terms of reference, IMR template (appendix 5), chronology template (appendix 6) and timeline for the SAR.

8.7 Once complete, the IMRs will be returned to the independent chair and circulated to the panel for scrutiny and assurance against the terms of reference.

8.8 The panel will reconvene to discuss the IMR and if necessary, authors will be requested to present their findings and answer any supplementary questions.

8.9 Section 45 of the Care Act 2014 requires agencies to co-operate and contribute to the carrying out of a SAR and provides a legal framework for the sharing of information.

8.10 Appendix 7 & 8 provide more detailed procedural information in relation to conducting a SAR using different SAR methodologies.

9. Links with other reviews

9.1 When setting up a SAR, the SSAB will consider how the process can dovetail with any other relevant investigations such as criminal investigations, inquests or other reviews (e.g. Domestic Homicide Review, Serious Case Review, and Health Serious Incident). The author of the SAR will need to liaise with other review owners at the outset in order to agree the relevant areas to be addressed and to reduce the potential for duplication.

9.2 Separate statutory guidance exists for the completion of Serious Case Reviews and Domestic Homicide Reviews, however there may be occasions when these overlap. Where there are possible grounds for other review processes to be activated a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair, with a final joint report being taken to all the relevant review commissioning bodies.

9.3 An overview of other statutory review processes is included at appendix 9.

10. Involving the person, their family and/or friends

10.1 Consideration will need to be given to the best way to notify the individual (if possible) and their family/carers (if appropriate) that a review is being undertaken. The individual will need to be notified that the review will analyse their records and notes held by public bodies involved in their care. Consent will be requested but is not required for a review to go ahead.

10.2 Consideration will be given at an early stage to the most appropriate method for engaging and involving the individual, their family and/or carers in the SAR. Contact will be made with all family members in the first instance to understand their desired level of involvement, this will be followed with written confirmation detailing with whom, and how frequently ongoing contact will be maintained.

10.3 Where appropriate, the Board will make arrangements for the individual(s) and / or their family and carers to participate in the Safeguarding Adult Review. The individual and/or family will be asked to contribute to the terms of reference should they wish to.

11. Report and Recommendations

11.1 Following the return of the IMR, thorough analysis and discussion by the SAR panel, the panel members along with the independent report writer will agree the key findings and recommendations for inclusion in the final report.

In developing the recommendations, it is proposed that conversations take place with the organisation they relate to, to ensure suitability and relevance. The agency responsible for delivering the action will be engaged in outlining the specific and measurable outcomes needed to enhance learning.

11.2 The SAR report will include an analysis of what happened and why; identify the actions required to prevent a reoccurrence; and contain findings that are of practical value to organisations and professionals.

11.3 Where appropriate, arrangements will be made to share the report and its findings with the individual(s), and / or their family and carers. Where possible and practicable the individual(s) and / or family and carer will be consulted with to agree how the person(s) in the review will be referred to.

11.4 The chair of the SAR panel must ensure that all agencies that contributed by completing an IMR are satisfied that their information is fairly represented in the final report.

11.5 The final report will be reviewed by the SAR subgroup before being signed off by the SSAB.

11.6 An executive summary will also be agreed which outlines the issues and highlights the recommendations.

12. Publication and Media

12.1 The SAR subgroup Chair, in consultation with the SSAB Chair, will consider appropriate publication of the report on a case by case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

12.2 Any media and communication issues will usually be co-ordinated by the council's Communications Team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.

12.3 In the majority of cases, the Executive Summary will be published on the website of the Safeguarding Adults Board. The Chair of the Safeguarding Adults Board will release a statement where appropriate.

13. Implementation and Evaluation

13.1 The real value of the completion of a Safeguarding Adult Review is to ensure that the relevant lessons have been learnt and that professional multi-agency safeguarding is improved, in order to prevent the issues in question happening again.

13.2 The SAR subgroup will consider the recommendations from the report and agree an action plan (if required).

13.3 The SAR subgroup will be responsible for ensuring the implementation of the action plan, monitoring the progress made and making links with relevant subgroups of the Board as required.

13.4 Following the completion of a SAR, learning will be cascaded through single and multi-agency learning and development opportunities and SSAB bulletins.

List of Appendices

Appendix 1 – SAR notification form

Appendix 2 – Template to request agency summary of involvement

Appendix 3 – Roles and responsibilities of people involved in the SAR process

Appendix 4 – Template to request IMR

Appendix 5 – IMR template

Appendix 6 – Chronology template

Appendix 7 – Procedure for completing a SAR using traditional methodology

Appendix 8 – Procedure for completing a SAR using a multi-agency case audit

Appendix 9 – Other statutory review processes

Appendix 1 – SAR notification form

SAFEGUARDING ADULT REVIEW (SAR)

NOTIFICATION OF DEATH / SERIOUS INCIDENT CONCERNING AN ADULT

1. Adult at risk's details	
Name:	
Address	
Date of Birth:	
Date of Death (if relevant):	
Ethnicity:	
Name and address of GP:	Name:
	Address:

2. Section 44 criteria	
Criteria 1: Working together issues	
Is there a reasonable cause for concern about how the Safeguarding Adults Board, members of, or other persons with relevant functions worked together to safeguard the adult?	
Criteria 2: Basis for a SAR. Is your view that **A duty for a SAR has be met?; or** **The Board should consider using its discretionary power to arrange for a SAR?**	
The adult has died, and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).	
The adult is still alive, and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.	
Or for SSAB to arrange for there to be a review of any other case involving an adult in its area with needs for care and support. (Whether or not the local authority has been meeting any of those needs).	

3. Details of concern	
Cause of death as set out in the death certificate (if appropriate) or suspected type of abuse or neglect	
Family / Next of Kin / Nearest Relative / Advocate / Representative:	

Date of incident:	
Location of Incident:	
Brief Summary of the Case: (Including notes of any Safeguarding meetings held)	
Other agencies known to be involved:	
Identify the factors that suggest this case meets the criteria for an SAR:	
Date of Notification:	
Name of Referrer:	
Agency of Referrer:	

SSAB office only

Date of notification to SAR group:	
Date considered by SAR group:	
Decision/Action taken:	

Please be aware that when this form has been completed, it will contain information that is personal and sensitive. When sending it to the Surrey Safeguarding Adults Board you must ensure you comply with all relevant data protection laws and, if relevant, your agency's information sharing policies.

Members of the public can use this form and should protect the document with a password and send the password separately to the Surrey Safeguarding Adults Board or alternatively send it by post.

Where to send the form:

By email to: surreysafeguarding.adultsboard@surreycc.gov.uk
By post to: Surrey Safeguarding Adults Board, Room 205, Old Millmead House, Millmead, Guildford, Surrey GU2 4BB

Appendix 2 – Agency summary of involvement

Summary of Involvement:

A SAR notification has been received for the person detailed below.

Please complete this form with information from your organisation only. The information you supply on this form will be used for the purpose of deciding whether the criteria for holding a Safeguarding Adults Review has been met. Section 45 of the Care Act 2014 provides the legal context for you to share information that is necessary and proportionate to assist the Safeguarding Adults Board.

The form is sent out to all agencies, you are asked to complete only those questions on which your organisation holds information, alternatively please indicate that this person and their family were not known to your services.

This pro-forma should be completed by the **Lead Safeguarding Adult's professional in your organisation** and sent to the Safeguarding Adults Board Manager by secure email with the appropriate protective marking.

Name of Agency:	
Name and Job Title of Lead Safeguarding Adults Professional:	
Contact Telephone Number:	
Email:	
Name Of Adult(s): (completed by SAB)	
Date of Birth: (completed by SAB)	
NHS/Framework/ID Number(s): (completed by SAB)	
Address(es) known: (please add any other addresses on your records)	
Timeframe identified for Review: (completed by SAB)	
Summary of Case: (completed by SAB)	
Agency relationship with Adult:	
Date when your involvement with the adult started:	
Date when your involvement with the adult ceased:	
PLEASE COMPLETE AND RETURN TO XXX no later than	

Agency:		**Person identified for completing IMR and chronology should a review be undertaken:** (and e-mail)	

Factual summary of agency involvement:

Provide a brief factual and contextual summary of your agency's involvement with the adult for the time period identified for this Safeguarding Adult Review. Note the following key information:

- significant events, attendance at appointments;
- involvement of other agencies/friends/family (with contact info where possible);
- changes in level of need/engagement with agencies and
- referrals of concerns, and how these were received by other agencies.

(Additional sections of the table can be added if required by clicking on 'Layout' and then 'Insert Below')

Date:	**Summary of Involvement**	**Follow-up?**

List details of front line staff and manager working with individual:

Name:	**Position:**

Other known agencies working with the individual e.g. local voluntary services:

Organisation:	**Contact (if known):**

Details of any concerns about the adult/carer and the actions taken by the agency:

I confirm that this is an accurate Summary of Involvement in line with the Sussex Safeguarding Adults Review protocol.

Signed:_____ **Date:**_____

Job Title:_____

Please ensure that all information requested above has been passed to Senior managers within your agency prior to returning to the Safeguarding Adults Board.

Appendix 3 – Roles and responsibilities of people involved in the SAR process

These are the individual roles that are usually expected when undertaking SARs:

Chair of Safeguarding Adults Board

- Retains strategy oversight of the SAR process
- Supports the SSAB to fully consider the merits of a referral
- Assist in arbitrating issues that are problematic; enable the SSAB to understand the findings of a SAR

Chair of SAR Subgroup

- Receives SAR referral
- Arranges subgroup consideration
- Refers to the SSAB Independent Chair
- Acts as intermediary between SAR subgroup and SSAB
- Senior point of reference for SAR panel
- Oversees SAR recommendations, implement and monitor action plan to achieve recommendations

Oversight Report Author

- Leads overview of SAR review
- Agrees final Terms of reference to share with panel
- Link to relevant agencies
- Writes SAR report
- Proposes SAR recommendations
- Presents to SSAB

Independent Chair SAR Panel

- Leads overview of SAR review
- Links to relevant agencies
- May write the SAR report
- May propose SAR recommendations
- May present to SSAB

Board Manager

- Enables practical delivery of SAR Panel process
- Acts as intermediary between SAR subgroup, Oversight Report Author and the SAR Panel
- Liaises with individual(s) and / or family members where appropriate

PRIVATE & CONFIDENTIAL

Dear

Re: Individual Management Review

Name:
DoB:
DoD:
Address:

A decision has been made that the above named person is to be made subject of a Safeguarding Adults Review.

On behalf of the Surrey Safeguarding Adults Board, I am writing to formally request that your agency undertakes an Individual Management Review (IMR).

The purpose of the Safeguarding Adult Review (SAR) is to learn lessons from this case and apply these lessons to prevent future occurrences. Safeguarding Adult Reviews are not enquiries into who is culpable for the death or harm suffered by the adult.

The Care Act 2014 places a requirement on Local Safeguarding Adults Boards to arrange for a SAR to be held when specific criteria has been met. The Care Act also legislates for the sharing of information to assist with the completion of the SAR. The relevant legislation is attached as an appendix to this letter.

The information your organisation supplies as part of the Individual Management Review (IMR) will be considered as part of the overall Safeguarding Adult Review report. The report is being written by an Independent Author, commissioned by the Surrey Safeguarding Adults Board for the purpose of identifying multi-agency learning.

The author of this SAR has worked with the family in this case to develop and agree the terms of reference. The full terms of reference are attached as an appendix, this includes the need to:

- Identify and evaluate the decisions, assessments and plans made by your agency regarding the individuals concerned.
- Examine the level and effectiveness of information sharing within your own organisation and externally with others.
- Review the safeguarding practices and processes in place at the time.
- Highlight ways in which practice can be improved.

A template for your organisation's IMR and chronology of involvement is attached to this letter. The person conducting the IMR on behalf of your organisation should have had no direct involvement with the subject of this review or with the staff involved in her care. The findings from the IMR should be agreed and accepted by you as the Senior Officer within your organisation for ensuring that the recommendations are acted upon. Once areas for improvement in practice are identified it is expected that actions will be taken immediately, rather than waiting for the final SAR report to be published.

Your organisations completed IMR should be returned electronically to surreysafeguarding.adultsboard@surreycc.gov.uk by XXXX.

Please can you confirm, within 3 working days of receipt of this letter, the following:

1. That you will be commissioning an IMR within your agency and will send the completed report within the required timescales.
2. The details of the IMR author (name and contact details including telephone and e-mail)
3. The name of the senior manager within your organisation who will 'sign off' the report upon completion and prior to submission.

The Senior Manager who signs off the report may be called to present the report to the panel and answer any outstanding questions the panel members may have. The requirement to do so and the date and time of this panel meeting will be confirmed shortly.

Please do not hesitate to contact me if you wish to discuss this matter further.

Yours Sincerely,

Independent Chair of the Safeguarding Adults Review Panel

Appendix A – Care Act Legislation
Appendix B – Terms of Reference
Appendix C – IMR Guidance and Template
Appendix D – Chronology Template

Care Act 2014 Legislation in relation to SARs

The below information is taken from the Care Act 2014 and provides the legislative framework for completion of a Safeguarding Adults Review and the sharing of information.

Section 44 Care Act 2014 – Safeguarding Adult Reviews

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

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) condition 1 or 2 is met.

Condition 1 is met if—

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if:

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

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

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

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

Section 45 Care Act 2014 – Sharing of Information

If a SAB requests a person to supply information to it, or to some other person specified in the request, the person to whom the request is made must comply with the request if:

a) conditions 1 and 2 are met, and
b) condition 3 or 4 is met.

Condition 1 is that the request is made for the purpose of enabling or assisting the SAB to exercise its functions.

Appendix 5 – IMR template

INDIVIDUAL MANAGEMENT REVIEW
GUIDANCE AND TEMPLATE

IMR AUTHOR DETAILS	
Name	
Role	
Office Location	
Telephone Number	
Email Address	
Completion Date	
Signature	
SENIOR OFFICER SIGN OFF	
Name	
Role	
Date	
Signature	

AGENCY NAME

SUBJECT NAME

DOB/DOD

DOCUMENT HISTORY				
Version Number	Version Date	Requestor of change	Summary of change	Approval

Guidance

This document is intended to provide an individual management review (IMR) of the decisions, actions taken and services provided to xxx while they were being provided services by xxxxx

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

The findings from the IMR should be endorsed by the senior officer within the organisation who has commissioned the review and who will be responsible for ensuring that recommendations are acted upon.

The IMR and associated chronology provides a documented history of involvement. It brings together all relevant decisions, actions and information and draws conclusions from the engagement between the individual and organisation.

The following format should guide the preparation of the IMR, to help ensure that the relevant questions are addressed and to provide information to the SSAB in a consistent format to assist with preparing the report.

1. Introduction

1.1. Reason for Review

This will be provided by the Chair at the start of the SAR process.

1.2. Terms of Reference

Include the specific terms of reference agreed by the SAR group.

1.3. Individual Summary

Describe the person, their social, religious, cultural likes and dislikes; their relationships with family and friends; their support network. Include an overview of their needs.

1.4. Contextual Summary

Provide a brief factual and contextual summary of your organisations involvement with the vulnerable adult for the time period identified for their safeguarding adult review.

1.5. Service Summary

Provide an overview of how the service was delivered at the time of the incident occurring. For example;

- CQC inspection outcomes
- Safeguarding procedures in place
- Risk Management policies
- Organisational structure
- Management and Supervision practices
- Volume of work
- Staff turnover, sickness, workloads
- Training offer
- Significant national/local policy changes

2. Methodology

Record the methodology used for completing this IMR, including:

- How was the review carried out?
- Which documents were reviewed?

- Who was interviewed and when?
- Any information that was not available

3. Organisational Involvement

3.1. Chronology of Involvement

Complete the chronology template to provide a comprehensive history of the contact professionals within your organisation had with the vulnerable adult and the perpetrator over the time period referred to in the terms of reference.

Provide a short summary of the key events with the full chronology attached as an appendix to the IMR.

3.2. Analysis of Involvement

Provide a detailed analysis of the organisation's involvement with the vulnerable adult:

- Consider the events that occurred, the decisions made, and the actions taken or not.
- Assess organisational practices against the policy, guidance and legislation in place at that time.
- Address the terms of reference but also consider any other critical factors.

4. Effective Practice / Lessons Learned

4.1. What has been learned from this case?

- Include details of guidance and policy that has subsequently been changed which would have mitigated this.
- Is there good practice to highlight?
- Are there lessons in how practices can be improved?
- Are there implications for ways of working – training, policies, supervision, information sharing, and working with partners?

5. Recommendations

Detail any recommendations specific to the key findings of the IMR and clearly state the outcomes they are seeking.

Recommendation	Actions Required	Owner	Time-scale	Success Criteria	Monitoring / oversight

Appendix 6 – Chronology template

The chronology is a working document which should be used to gather information on which to base the IMR analysis. It is a basis upon which the author can refer back to and expand upon throughout the review. This should be a comprehensive chronology of involvement by the organisation and/or professionals in contact with the subject of the review, and their family, over the period of time set out in the review's terms of reference. Depending on agreed timescales and type of review, chronologies may be submitted prior to, or at the same time as, IMRs.

What to put in the table?

Please keep to the following rules when entering events into the table at the end of this document.

Heading	Details Required
Date	Start Date. **This column must always be completed.** Chronolator recognises a variety of formats, such as '31/12/03', '31.12.03' or '31 dec 03'. If you are unsure of the exact date, enter your best estimate and note that you have done so in the 'Comments' column. If you want to enter a range of dates, enter the first date in this column and the other date in the 'Comments' column.
Time	Start Time. Chronolator recognises a variety of formats, such as '1305', '1 05 pm'.
Source of Information	Where did you obtain the information (e.g. Health Visitor records, duty team log etc.)? You do not need to enter details of your own organisation or department here. Chronolator will add them when the Administrator merges your chronology. **This column must always be completed.**
Contact with Adult	
Contact with Family	
Communication - within agency	**Authors should not assume another agency will include an event/contact in their chronology, if it is identified in records it should be included in the chronology.**
Communication - external to agency	**Authors should not assume another agency will include an event/contact in their chronology, if it is identified in records it should be included in the chronology.**
Response or Outcome	
Comments	**Author's Comments** – this may highlight a point that the IMR author can expand upon in the full report document, make reference to good practice or an area for improvement. This section should include any comments that have come from interviews with the staff or any comments made by management on the staff performance. The author may also make comments on any additional actions made or link the event to another in the chronology. It will also include anything else that

Heading	Details Required
	the author considers as significant, often unique to each agency, e.g. housing move, arrests, school reports, etc.

Date	Time	Source of Information	Contact with Adult	Contact with family	Communication - within agency	Communication - external to agency	Response or Outcome	Comments

Appendix 7 – Procedure for completing a SAR using traditional methodology

On confirmation of a SAR being commissioned using the traditional safeguarding adults review methodology, a core group will be established, this will be led by the appointed Independent SAR Chair.
The SAR Core Group will consist of representatives of:

- Surrey County Council, Adult Social Care
- Surrey Police
- NHS Clinical Commissioning Group
- Any others who may have specific expertise in relation to the case.

At the initial meeting, the group will determine the terms of reference and confirm the agencies to be approached to complete an Individual Management Review (IMR). Following this meeting, the Chair of the SSAB will formally request relevant agencies and independent bodies to prepare and submit an Independent Management Report and chronology of their involvement with the person and, where necessary, an agency action plan.

Guidance will be provided to agencies/services to enable them to focus their report on the specific issues identified by the panel in their involvement with the individual(s) service and/or family.

The Individual Management Review, chronology, plus any other information identified as necessary, must be sent securely to the Board Coordinator within an agreed period which should not exceed 10 weeks of the report being requested. If agencies or organisations fail to cooperate and provide the information requested this will be escalated to the Chair of the SSAB and, where appropriate, to their regulatory body.

The agency/service chronologies will be amalgamated, if possible, and all the documentation will be forwarded by the Board Coordinator/Administrator to the chair of the SAR to view the IMRs. A meeting of the SAR core group will be convened to consider the contents of the IMRs and to discuss and consider the main points to be included in the overview report. Prior to this meeting, copies of the IMRs must be passed through secure electronic systems to all the members of the panel at least two weeks before the planned meeting.

Panel members may request that their IMR author attends the meeting with them to address any queries that arise. If the panel member wishes their IMR author to attend the panel meeting with them, it will be their responsibility to send their IMR author copies of the combined chronology and IMRs so that they may have an opportunity before the panel meeting to check out any specific issues identified from the chronologies and IMRs of other agencies/services.

If requests for further information are made at this core group meeting agencies will be given an agreed period of time to provide the clarification required. The independent author (or SAR chair if author not appointed) will then draft the overview report, executive summary and recommendations. These will be passed to the Board Coordinator to circulate to the members of the core group in advance of their next meeting, for their consideration and comments. The number of meetings of the core group to consider the overview report, executive summary, recommendations and to produce an action plan will depend on the complexity of each case. Some level of e-mail communication could reduce the number of meetings required.

The Independent SAR Chair will present the final overview report, executive summary and draft action plans to a panel meeting, for final agreement and the agreed documents will be forwarded by the Board Coordinator/ Administrator to the Chair of the SSAB.

A communications meeting is to be convened once the Independent Chair of the SSAB has confirmed the report is to be tabled at the next SSAB meeting. This group is responsible for drafting the press release for SSAB to consider at the meeting.

Arrangements will be made by the Board Coordinator for the report to be presented to the SSAB. The report must be presented by the Independent SAR Chair and/or Author. The SSAB will agree the final report, recommendations, action plan and communications plan. Board members will make a decision on a case by case basis on whether to publish the full overview report with the executive summary.

The individual agency/service action plans will be monitored by the agency/service concerned. The SSAB will monitor the overview report action plans through the Safeguarding Adults Review sub-group. This group will report progress of the plans to the SSAB at each meeting, with any concerns regarding the non-compliance or delays in implementation of the individual agency/service action plans.

SSAB members are required to make arrangements to disseminate the overview and executive summary reports, recommendations and action plans within their agencies.

The SSAB and its subgroups will share and act upon any recommendations/ learning and will arrange SAR learning events.

The Independent Chair of the SSAB will address any media enquiries arising from the SAR.

The SSAB will agree appropriate arrangements for the publication of an anonymised report, recommendations and actions points on the SSAB website.

Appendix 8 – Procedure for completing a SAR using a multi-agency case audit process

The SAR sub-group may recommend the multi-agency audit process as an effective way of addressing some or all of the following:

- audit scrutiny
- a lessons learned approach
- benefits for Surrey communities
- prevention and practice improvement
- improved partnership working

The aims of the process are:

- To determine if there are any lessons to be learnt to improve interagency working.
- To analyse the information submitted by agencies /services involved in the case.
- To produce recommendations regarding actions; policy, protocols and practice, where necessary.
- To submit the above to the SSAB for consideration and dissemination.
- To promote continuous professional development of good practice across all agencies and services.
- To identify training needs.

The process is not intended to attribute blame for the events related to the safeguarding concerns but to ensure the effectiveness of multi-agency safeguarding practice. Each agency and service is responsible for ensuring that their internal procedures support the prevention of abuse and the protection of adults at risk.
If, when engaging in the process, concerns are raised about any internal procedures or the conduct of any staff or managers within the agency or service, it is the responsibility of that agency or service to address these concerns. The agency/service should advise the Independent SAR Chair and the group that appropriate action(s) has been taken.

An independent SAR Chair may be appointed to lead the review. The roles and responsibilities of the Independent Case Audit SAR Chair are as follows:

- To Chair the Case Audit Meeting;
- To read and analyse the summary of agency involvement sheets and chronologies to develop key lines of enquiry for the meeting;
- Develop terms of reference for the meeting.
- To produce a detailed summary report, to include recommendations and to highlight good practice.
- To present the summary of the case and findings at the relevant board/partnership, lesson learnt Seminars and any other events as required.

The Case Audit Group should be made up of representative senior managers from the key agencies involved in the scope of the case. The Group may co-opt any additional members to address particular cases or issues.

The roles and responsibilities of the group are to:

- be informed of agency summaries of their involvement
- be informed of any actions taken so far
- make recommendations for any outstanding actions that may be required to guarantee safety and reduce or remove risk
- make recommendations for lessons learned
- identify the circulation of post group communications
- Identify any training needs
- Recommend any changes that may be required to the SSAB multi-agency policy, protocols and practice guidance
- Pass all recommendations to the Safeguarding Adults Review sub-group to monitor agency progress and completion of agreed actions.

The Board Co-ordinator will advise the Independent Chair of the SSAB that a case has been referred from the SAR sub-group for audit. The referral will recommend the agencies and individuals who need to be involved. The Independent Chair of the SSAB will approve the process to move forward and the SSAB Board Co-

ordinator will make the necessary arrangements, for the Group to meet, aiming to achieve this within 8 weeks from the point of referral, if possible.
The following actions should be carried out:

- The Board Co-ordinator should ascertain details of the organisations that had involvement in the case. Relevant safeguarding leads are to assist with this action.
- A letter should be sent to the senior managers of the organisations involved advising of the decision of the Independent Chair of the SSAB for a case audit to be carried out.
- That manager should be requested to provide a summary of their organisation's involvement in the case and include a chronology of actions / events using the agreed template. They may include, within their summary of involvement, any concerns they had about the safeguarding case or what they would do differently in the future.
- A copy of all agency summaries of involvement, complete with chronologies, should be submitted to the Board by a secure e-mail within 4 weeks of the request being received.

Organisations that had involvement in the safeguarding case should nominate a representative from their organisation to attend the meeting to clarify information and actions taken.

The Board Co-ordinator will forward, securely, summaries and chronologies to the Group members, 2 weeks in advance of the panel meeting.

The meeting will be convened at the earliest possible time, with an independent SAR Case Audit Chair if necessary. Attendees must prioritise attendance, given the subject matter, concerns and activity of their own agency. The SSAB Board Co-ordinator or Administrator will take notes of the main issues identified during the discussions and the group will:

- Consider the terms of reference
- Hear the case summaries from each agency
- Be cognisant of chronologies
- Discuss and agree the key learning points, from which a range of recommendations will be set out and assigned to appropriate agencies.
- identify any specific issues that have not so far been addressed and consequently expect the relevant agency to develop an action plan
- Identify the scope of circulation of the learning and consequent recommendations

The SAR Case Audit Chair will draft a summary report which will contain a summary of the case and the recommendations made by the Group, including any outstanding actions that need to be taken. This will be circulated to Group attendees with an action plan template for completion. It will also be shared with the Chair of the Safeguarding Adults Board.

The action plan is to be populated by all identified agencies and returned to the SSAB by the deadline set, approximately 3 weeks. The collated action plan will be presented to the SAR sub-group for quality assurance. Once approved the case audit report and action plan are to be tabled for the next SSAB meeting, the report should be presented by the SAR Case Audit Chair.

Recommendations and action points will be referred to the SSAB and its sub-groups who will share and act upon to monitor agency progress, via agency reporting against any actions identified. The Delivery group will also be cited on the report and action plan, to ensure they take any appropriate action.

Where the above may involve national agencies such as for example: professional bodies; NHS England and or other Regulatory Bodies, the Independent Chair of the SAB will request evidence that each agency has written to their associated regulator to share the recommendations and or action points.

Appendix 9 – Other statutory review processes

The Board acknowledges that the following are statutory:

- Serious Case Reviews concerning children https://www.surreyscb.org.uk/case-reviews/
- Domestic Homicide Reviews https://www.gov.uk/government/collections/domestic-homicide-review
- MAPPA Serious Case Reviews https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf
- Mental Health Homicide Reviews https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/
- Serious Incident https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

The Learning Disabilities Mortality Review (LeDeR) Programme is a National Programme which reviews all deaths of people with a learning disability, aged 4 years and over. There are LeDeR Local Area Contacts in each Local Authority. LeDeR is not a statutory process but is an NHS 'Must Do' and a national priority. It does not replace the SAR process but can run concurrently with a SAR. A LeDeR may trigger a statutory process if multi-agency learning needs are identified for the local area. Each Board should have in place appropriate links between the LeDeR and the SAB so as learning to improve adults with care and support needs is shared. Business Managers and the LeDeR Local Area Contact should ensure practical arrangements for running reviews concurrently are taken into consideration at the commencement of reviews, particularly where this involves family involvement and access to patient records.