Safeguarding Adult Reviews Protocol

Version 2 – July 2020

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1. Introduction

This document provides guidance on the process for managing a Safeguarding Adult Review (SAR) in Barnsley. The requirement to undertake Safeguarding Adult Reviews is contained in the Care Act 2014 and Chapter 14 of the Care and Support Statutory Guidance (updated March 2016).

2. What is a Safeguarding Adult Review?

Section 44, the Care Act 2014 stipulates that Safeguarding Adults Boards (SABs) must arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult with care and support needs, 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 was likely to have died but for an intervention, or 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 may arrange for a SAR in any other situations involving an adult in its area with care and support needs, whether or not they are being met by the Local Authority. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from 'near misses' and situations where the arrangements worked especially well. The SAB decides when a SAR is necessary, arranges for its conduct and if it so decides, implements the findings.

The criteria are met when:

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect; **and one of the following:**
- Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
- Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
- Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.

There is an expectation that individuals, agencies, organisations, cooperate with the review but the Act also gives Boards the power to require information from relevant

parties. The SAB should decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings.

SARs should reflect the six safeguarding principles and should also apply the following principles:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

3 What is the purpose of a Safeguarding Adult Review?

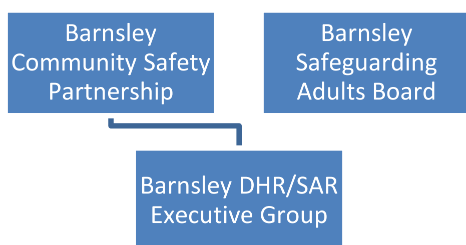
The purpose of all SARs is to keep the focus on learning. The final SAR report and those responsible for disseminating the learning from it, should ensure that the recommendations can be translated into practice, not just for those involved but to a wider audience to support ‘prevention strategies’ and influence strategic plans.
It is not for a SAR to investigate how a death or serious incident happened. Neither is it the responsibility of the SAR to apportion blame. Such matters will be dealt with by the Coroner’s or criminal courts, or other bodies.

4 Who has responsibility for commissioning a SAR?

The overall responsibility for establishing and conducting a SAR rests with the Safeguarding Adults Board of the Local Authority area in which the victim was normally resident at the time of the incident.

If the victim had no established address prior to the incident, lead responsibility will rest with the area where the victim was last known to have frequented as a first option and then considered on a case by case basis.

In Barnsley the consideration of whether to undertake a SAR is delegated to an Executive Group of the Barnsley CSP/SAB. Note this is a joint group that considers Domestic Homicide Reviews and Safeguarding Adult Reviews at the same time.



5 Notification of a serious safeguarding incident

Any individual, agency or professional can request a SAR. This should be made in writing via e-mail to the Adult Safeguarding single point of contact at the mailbox below. The request should detail:

- What happened with dates if known;
- The views of the adult/family/carer;
- Where the incident/concerns took place;
- Who was involved and their organisation and
- Why the request is being made

The request should be considered against the criteria in order for a SAR process to be consistently applied. Agreement to a SAR should be recorded on relevant systems across the statutory agencies. For the NHS this will be carried out by the CCG who will record on STEIS; for the LA on the Erica IT system.

Appendix 1 shows a flowchart of stage 1 of the notification procedures.

Referrals should be made via secure email to the Adult Safeguarding single point of contact (SPC) as soon as possible after the incident via email at: ACAdultProtection@barnsley.gcsx.gov.uk

SPC to notify Barnsley's Safeguarding Adults Board Manager who will ensure that the Chair of the SAB is briefed on the circumstances.

Links with other reviews and investigations

For victims of domestic homicide, there is separate statutory guidance in respect of children, which provides for a Serious Case Review (SCR) and in respect of persons aged 16 or over, which provides for a Domestic Homicide Review (DHR). These two sets of statutory guidance overlap where the victims are aged between 16 and 18.

When commissioning a SAR there should be consideration of how it how will dovetail with other statutory reviews and any other investigations.

The guidance for DHR states consideration should be given to how the child SCRs and DHRs can be managed in parallel in the most effective way, so that organisations/professionals can learn from the case. Different types of reviews will have their own specific areas of investigation and these should be respected. Where intelligence can be shared across reviews, there should be no organisational barriers to

information sharing. It is also helpful to consider if some aspects of the reviews can be commissioned jointly to reduce duplication.

Coroners

Any SAR may need to take account of a Coroner's inquiry, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay. Coroners are independent judicial officer holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations;
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home);
- Deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.

In the above situations the local SAB should give serious consideration to instigating a SAR.

6 Barnsley DHR/SAR Executive Group

In Barnsley the consideration of whether to undertake a SAR is delegated to an Executive Group of the Barnsley CSP/SAB.

Aim of the Executive Group

- To share historical and current agency information known about the victim / perpetrator / family / household members or known significant others.
- To share information about the events surrounding the death of the victim.
- To identify any parallel review processes which may be planned or underway in relation to the incident, and the implications of these for DHR/SAR arrangements.
- To advise the SAB Chair on whether the statutory criteria for undertaking a SAR have been met and accordingly whether a SAR should be commissioned.
- To identify those best placed to sit on the Safeguarding Adult Review Panel (where applicable) and its terms of reference.

Where the Executive Group agrees that a situation does not meet the criteria for a SAR but agencies will benefit from a review of actions, other methodologies can be considered. These include:

- Serious Incident Review: Organisations should use their own SI procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations.
- Management Review: A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue.
- Reflective Practice Session: The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the

Safeguarding Lead or other such suitable person, including an independent facilitator.

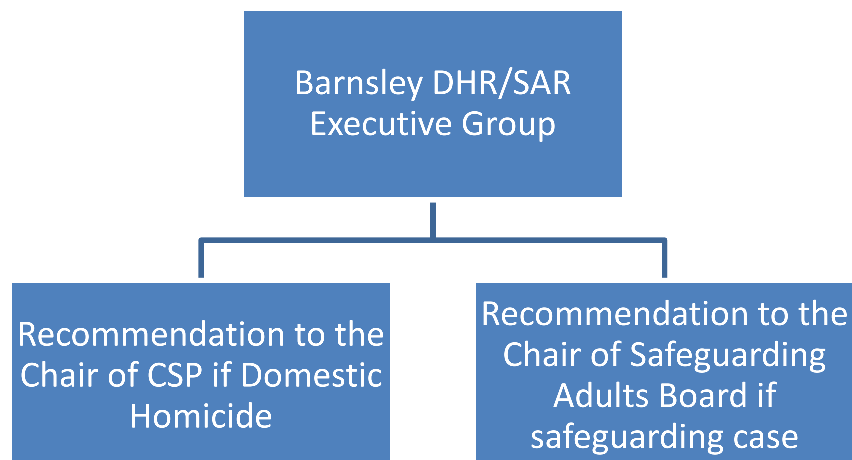
Membership

Core membership of the Executive Group comprises of:

- Barnsley Council services including Adult Services, Safer Communities, Healthier Communities, Safeguarding Adults and Children.
- South Yorkshire Police.
- Barnsley Clinical Commissioning Group.
- SWYFT.
- National Probation Service
- Barnsley Hospital Trust (BHNFT)

Any other local or national agency which had or may have had involvement with the victim, perpetrator or their families and households should also be invited to contribute to and attend the Executive Meeting. The following examples of those who should be considered are not exhaustive:

- Registered providers i.e. Housing Associations and Social Landlords
- HM Prison Service
- Independent Health professionals, e.g. GPs and Dentists
- Schools
- Crown Prosecution Service
- The Police Family Liaison Officer
- Representatives of the Voluntary and Community Sector (VCS) with expertise in domestic violence and abuse



Servicing the meeting

The Executive Group meeting will be chaired by the Chair of the SAB.

Executive Group meetings will be serviced by the Council's DHR business support officer. To enable members of the meeting to be fully prepared the officer will:

- Notify core members that the meeting date they have on hold in their calendars for DHR/SAR executive meetings will take place.
- Using the letter and information in **Appendix 2 and 3** to seek clarification from agencies on any information held about the victim. Note – Appendix 3a (chronology) does not need to be completed at this stage.
- Using the letter in **Appendix 4**, send invitations to executive group members and all other known agencies which had had involvement with the victim, perpetrator or their families and households to attend the DHR/SAR Executive Group meeting.
- Using Appendix 3 information, compile a summary for the Chair of each case in preparation for the meeting.
- Ensure that those attending have an electronic copy which, for people outside the Council, is sent securely via GCSX or Egress.
- Ensure that the Chair has hard copies.
- Prepare agenda as set out in **Appendix 6**.
- Attend the meeting and take action notes and record decisions.
- If a decision is taken to conduct a SAR then the SCP should send out the chronology in Appendix 3a to agencies identified as being involved. .

Timescales

All requests will be submitted to the Executive Group with the authority to consider the referral. The Executive Group will be established within **15 working days** of the notification.

The Executive Group will consider the criteria for the undertaking of a DHR/SAR. The conclusions of the Executive Group and their recommendations should be provided in writing **within 10 working** days of the meeting to the Chair of the Safeguarding Adults Board, who will make the decision on whether there should be a review **within 15 working days.**

7 Decision to Conduct a Safeguarding Adult Review

The decision on whether to hold a SAR should be taken by the Chair of the SAB. The draft Terms of Reference for the SAR should be approved in conjunction with this decision. (See **Appendix 9** draft terms of reference)

Barnsley's Safeguarding Adults Board Manager, on behalf of the SAB Chair, must inform the victim's family, in writing, of the SABs position regarding whether a SAR will be conducted. (See **Appendix 8** letter)
If the family disagree with the decision reached by the panel, their appeal will be considered by the Chair, South Yorkshire Police, Clinical Commissioning Group and Barnsley Council (as the statutory partners within 28 days of the appeal being received)

8. Conducting the review

Once a decision has been taken to conduct a review the following must be put into place:

8a. Terms of reference

The Chair and members of the DHR/SAR Executive Group will be responsible for preparing draft Terms of Reference, which are proportionate to the circumstances of the case, once the decision has been made to recommend conducting a SAR (See **Appendix 9**).

8b. Appointment and Role of the Review Panel Chair and Report Author

The SAB Chair and SAB Board Manager will select from the Review Panel Chair from a list of contacts or from an external selection process.

The Review Panel Chair should be an experienced individual who is not directly associated with any of the agencies involved in the Review.

The Review Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the Individual Management Reviews (IMRs – see below) and any other evidence the DHR Panel decides is relevant.

Consideration should be given to the skills and expertise required to effectively Chair a SAR). They should have the appropriate core skills including:

- Strong leadership and ability to motivate others;
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- Collaborative problem solving experience and knowledge of participative approaches;
- Ability to find and evaluate best practice;
- Good analytic skills and ability to manage quantitative and qualitative data;
- Knowledge of safeguarding adults;
- Ability to write for a wide audience and
- An understanding of the complexity of the health and social care system

The Review Panel Chair is responsible for the final decision on the suitability of the draft SAR Terms of Reference and should agree these at the first meeting of the Panel. The Terms of Reference may, however, need to be revisited as the Review progresses and as new information is identified. Any amendments to the Terms of Reference will be agreed with the Review Panel by the Review Panel Chair.

The Review Panel Chair will establish an agreed timetable of Review Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of IMRs.

As part of the terms of reference, the Chair should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the Review in conjunction with Barnsley Council's corporate communications team.

The Review Panel Chair should as far as possible, ensure that the review process is a learning exercise in itself for all those involved in the case.

The Review Panel Chair will regularly update the Service Director Adults in BMBC People Directorate and the Chair of the SAB on progress with the SAR.

The Review Panel Chair will maintain contact with the Chair / Lead Professional of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

The Chair of the Review Panel should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

Where there is an on-going criminal investigation the Review Panel Chair will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

9. Individual Management Reviews (IMRs)

Individual Management Reviews (IMRs) will be commissioned by, or on behalf of, the Chief Officers of all agencies who have provided services to the victim, perpetrator, and family members or significant others identified in the Term of Reference within the time period specified there.

The IMR should begin as soon as an agency is advised by the SAB Chair of a decision to proceed with a SAR, and sooner if a death or serious incident of abuse or neglect gives cause for concern within the individual agency.

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

A format for IMRs and a standard IMR Template are provided at **Appendix 9**. These are held together with the terms of reference.

Full names and designations of individuals will be used in reports submitted to the Review Panel. Any material from them included in the Report will be anonymised towards the end of the DHR process and prior to wider dissemination. Every IMR should be accompanied by a detailed chronology of agency involvement with the individuals subject to the DHR (use template as in **Appendix 3a**).

The professional commissioned to conduct an Individual Management Review should not have been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR.

Chief Officers must ensure that the senior manager identified to complete the IMR is given sufficient time and any required resources to do so within the agreed timescales.

Those conducting Individual Management Reviews should consider carefully which staff and managers should be interviewed to inform the Review. The views of the Police Senior Investigating Officer and, where applicable, the Crown Prosecution Service must be sought prior to interviewing individuals who may be witnesses in criminal proceedings.

Staff should be reminded that the Review does not form part of a disciplinary investigation. The individual should be given the opportunity to have a supporter in attendance at interview and it is for the individual to decide who that should be. The role however is to support and not to represent the interviewee.

A written record of such interviews should be made. This should be agreed and signed by both the interviewee and the interviewer, with any areas of disagreement noted.

The IMR reports should be quality assured by a senior manager in the organisation on behalf of the Chief Officer

10. Timescales for Conducting a Safeguarding Adult Review

The SAB will aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings.

To meet this timescale it is essential that senior managers identified to complete IMRs are given sufficient time and any required resources to do so.

The complexity of the SAR (as well as ongoing criminal justice or other legal proceedings) may prevent the SAR being completed within the above timescale. This may not become apparent until the Review is in progress.

As soon as it emerges that a SAR cannot be completed within the timescales above the Review Panel Chair should discuss this with the Chair of the SAB.

In all cases the aim should be to draw out lessons and act upon them without delay and without necessarily waiting for the SAR to be completed. This is particularly important where an extended timescale for the SAR is required and in such cases all identified recommendations should be implemented as soon as possible.

Where completion of the SAR is delayed by criminal justice or other legal proceedings it should be completed without delay once those proceedings are concluded.

On completion of each IMR report, there should be a process of feedback and debriefing for the staff involved in the Review, in advance of completion of the Report. There should also be a follow-up feedback session with these staff members once the Report has been completed and prior to its publication. The management of these sessions is the responsibility of the senior manager in the relevant organisation.

11. Disclosure and Criminal Proceedings

Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair processes is a vital component of a fair system. The Criminal Procedure and Investigations Act [1996] provides the legislative framework for disclosure in criminal proceedings.

Material generated or obtained in the course of a SAR may be capable of undermining the prosecution case or assisting the defence and if a criminal prosecution is ongoing all such material must be made available to the Police Senior Investigating Officer and Disclosure Officer to assess whether it is relevant. Those officers will liaise with the Crown Prosecution Service as appropriate. Where material is held by a third party, prosecutors must take any steps they regard as appropriate to obtain it. This may include applying for a witness summons causing a representative of the third party to produce the material to the Court.

It is the responsibility of the Disclosure Officer to liaise with the Review Panel Chair regarding the disclosure of Review material, particularly where potentially disclosable material from the SAR is sensitive; although in most cases applications for access to material should be directed to the organisation which owns it.

12. Involvement of Family Members, Friends, and other Support Networks

Family members, friends, colleagues and members of informal support networks may have detailed knowledge that will enhance the quality and accuracy of the Review. The SAR Panel should recognise the benefits to be gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, where there are suspicions of 'honour'-based violence. The benefits include:

- Assisting the family with the healing process. Participation by the family also humanizes the deceased, helping the process to focus on the victims and perpetrator's perspectives rather than agency views.
- Helping families satisfy the often expressed need to contribute to the prevention of other deaths or serious safeguarding incidents.
- Allowing the Review Panel to get a more complete view of the victim's life and see the circumstances through the eyes of the victim. This approach can help the panel understand the decisions and choices the victim made.
- Obtaining relevant information held by family members, friends and colleagues which is not recorded in official records.
- Revealing different perspectives of the case, enabling agencies to improve service design and processes.

The Review Panel must ensure that family members, victims and alleged perpetrators (where appropriate) and updated on the progress of the review and the outcome.

The Review Panel should be aware of the potential sensitivities and need for confidentiality when meeting with members of informal support networks during the review and all such meetings should be recorded. Consideration should also be given at an early stage to working with the Police Family Liaison Officer and Senior Investigating Officer involved in the related police investigation to identify any existing advocates and the respective positions of family members, friends and other support networks with regard to the deaths or serious safeguarding incident.

When considering whether to interview family members, friends and other support networks, the Review Panel must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The Review Panel Chair will need to discuss the timescales for interviews with the Senior Investigating Officer (SIO) and take guidance from the SIO in relation to any ongoing criminal proceedings.

13. The Report

The SAR reports should provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence; be written in plain English; and contain findings of practical value to organisations and professionals.

The Report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and other reports together with information obtained from other sources.

It is crucial that the Review Panel Chair and, if applicable, the Report Author have access to all relevant documentation and, where necessary, individual professionals.

An Executive Summary of the Report should be prepared by the Report Author.

Template for SAR report:

Introduction

- Summarise the circumstances that led to the SAR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used, including the documents reviewed and whether the information was provided in an interview or through written evidence.
- List agencies and the nature of their contribution to the review.
- List the names and roles / positions / job titles of the SAR panel chair, the overview report author and the job titles and employing organisations of all the SAR panel members.
- In summarising the circumstances that led to the review it is helpful to refer to any strategy or other meetings where decisions were made, the dates of these meetings and any important points covered.

The facts

This section should include a narrative that tells the story in a straightforward factual way, using the chronology as a basis. This narrative can be lengthy and it is helpful to describe the detail of key events or episodes, but not translate the full chronology.

- Compile an integrated chronology of involvement of all relevant organisations, professionals and others who have contributed to the review process.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the victim, any perpetrator and the home circumstances of the victim.

Analysis

This should look at how and why events occurred, decisions were made and actions taken or not taken. In this section reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve. This is also where any examples of good should be highlighted

Conclusions and recommendations

The conclusions should highlight the key lessons learned from the SAR. Some final report authors may separately itemise the learning for each agency as covered in the

various agency reports. The conclusions should be clear about which factors supported good practice and which created, or contributed, to unsafe conditions in which poor practice was more likely to occur.

Recommendations should flow clearly from the analysis/learning identified in the case and be outcome focused, i.e. concentrate on the end result or desired change in practice or conditions, not the process required to get there. A limited number of SMART recommendations will be more effective in creating change than a long list without priority areas for action. Any lessons for national as well as local policy and practice should also be highlighted and information sent to the relevant government department.

The Report Author should maintain independence when drawing up the recommendations, but close liaison with the commissioning authority will produce more productive recommendations that fit with other developments already taking place. The final report is agreed by the Review Panel and the SAB. Any disagreement with the views of the report author should be set out in the report

On completion of the Report members of the Review Panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Report.
- Ensure that the Report is produced to a high standard.
- Translate recommendations from the Report into an outline Action Plan and agree this on behalf of their respective agencies (see below).

Once agreed, provide the anonymised Report and the Action Plan to the Chair of the Barnsley SAB.

14. Action plans

The SAR Action Plan should set out who will do what, by when, with what intended outcome and how improvements in practice and systems will be monitored and reviewed.

The Action Plan will be developed directly from the recommendations of the report. It will include all the individual agency report recommendations and any overarching cross cutting recommendations for more than one agency. The Action Plan should be realistic and set out clearly the responsible agencies/individuals and specific dates by which actions will be undertaken, as well as the desired outcomes. The SAR report should be clear about how the Action Plan will be monitored and evaluated.

The SAB is responsible for monitoring the SAR Action Plan through regular review until completion. Individual actions will be signed off as they are completed. Agencies should ensure that this is not a paper exercise. Actions must be meaningful and designed to actually make a difference to practice.

15. Findings from Safeguarding Adult Reviews

The findings from any SARs should be reported in the SAB Annual Report and what actions it has taken or intends to take in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report.

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

Media Strategy

It is essential to have an approved media strategy in place. Important points to consider are:

- Good communication between media / publicity departments across SAB agencies.
- Clear briefings for panel members, SAB, appropriate officers within agencies and elected members, so that all concerned are fully aware of when to expect media coverage.
- Clarity about who will lead the media response and the high level messages.
- Thoughtfulness about the actual wording of reports that will be published – imagine seeing the lines that are written in a newspaper headline or article
- Co-ordination with media releases from any other SCBs or agencies involved.

16. Learning from Serious Adult Reviews

The value of Serious Adult Reviews is in the learning derived from them. As much effort should be spent on acting on recommendations as on conducting the actual Review.

The following should help to secure maximum benefit from the review:

- Conduct the review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant Action Plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with adults.
- Make sure staff and their representatives understand what can be expected in the event of a SAR.

Appendix 1 – Flow Chart

DHR/Serious Adult Review Process

STAGE ONE

Step 1 – Initial notification

Notification to single point of contact (SPC) at ACAdultProtection@barnsley.gcsx.gov.uk – ***by e-mail within 48 hours***

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Step 2 – Informing key stakeholders

SPC notifies:
CSP/SAB Chair as appropriate
Executive Director Communities/People as appropriate
Services Director Communities
Services Director (Adults)
DHR lead Communities/SAB Board Manager as appropriate
Head of Safer Barnsley
Within 24 hours

→ Key stakeholders inform appropriate others on a need to know basis
Within 2 working days

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Step 3 – Coordination of intelligence

3a. SPC sends out a password protected letter and overview report template to key agencies to coordinate intelligence relating to deceased - ***within 48 hours***
3b. SPC receives intelligence & produces a summary report received from agencies
3c. SPC arranges a DHR/SAR Executive meeting - ***within 15 working days of notification email***
3d. SPC pulls together information for the executive meeting

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Step 4 – Executive Group Meeting

Executive meeting held to determine whether or not the case should be investigated as a DHR/SAR or neither

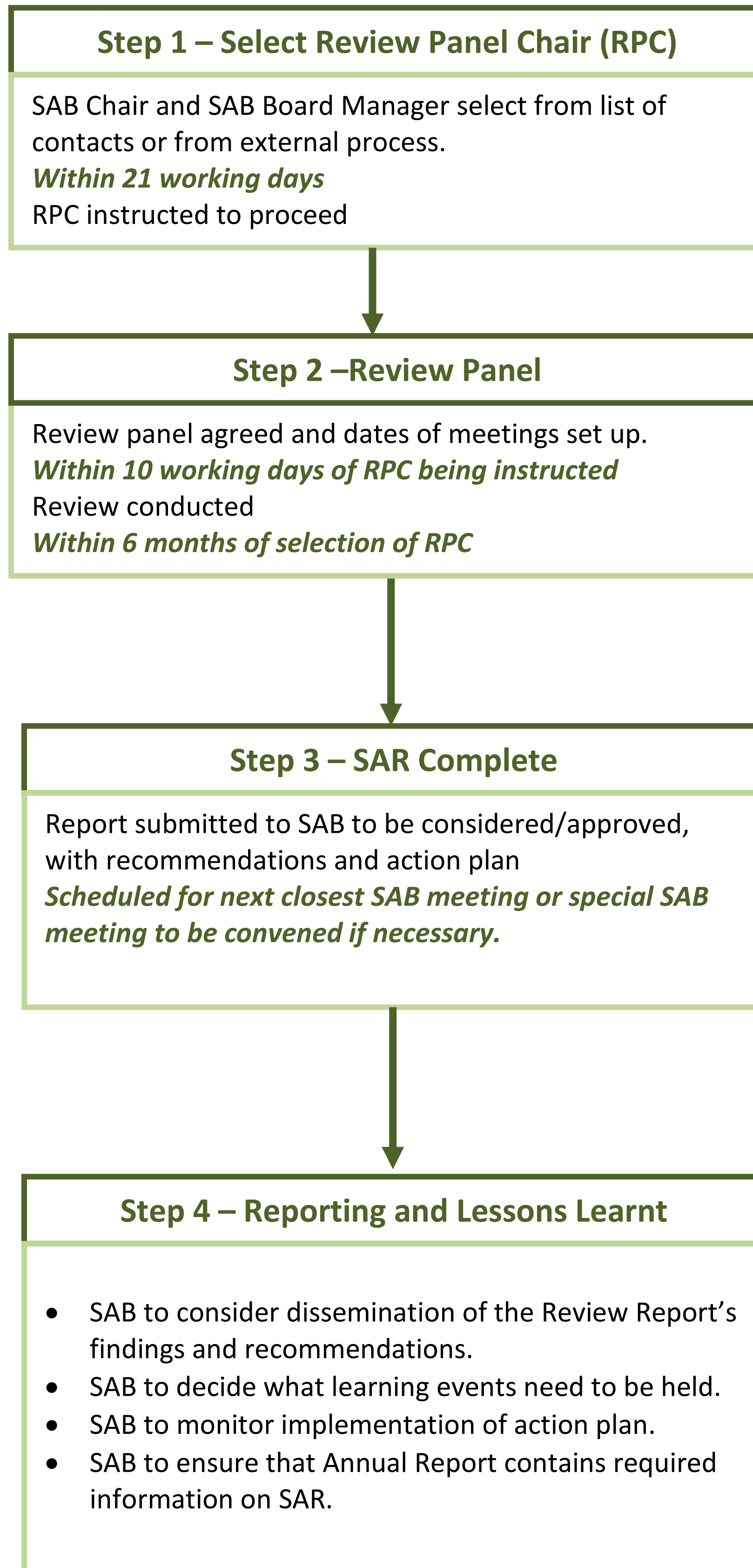
NO

Case closed

YES

Chair of Executive Group informs (via DHR Lead/SAB Manager, as appropriate) Chair of the CSP/SAB within ***10 working days***
Chair of CSP/SAB makes a decision if it should be a DHR/SAR ***within 15 working days***
If DHR, SPOC informs Home Office on behalf of the Chair of the CSP ***within 5 working days***

STAGE TWO – Safeguarding Adult Review



Appendix 2 – Letter requesting information

Dear Colleague

URGENT: SAFEGUARDING ADULT REVIEW

An incident has taken place that may require a Serious Adult Review to be convened under the Care Act 2014.

Please do the following **immediately**:

1. **Check to see if you hold records for the following people (please treat this information as sensitive and restricted):**

Name of victim:	Insert name, address, DOB
Name of alleged perpetrator:	Insert name, address, DOB
Other household members:	Insert name, address, DOB

Please complete the information requested in Appendix 3 attached to this letter. This is required to identify which agencies should attend the Executive Group meeting and which hold relevant information that would inform a Safeguarding Adult Review in the event of one being commissioned.

If you do hold records, secure them immediately by copying and/or restricting electronic access. To be completely clear, only staff who will be involved in the SAR process (should it proceed), should have access to the file from now on.

Please then contact ACAdultProtection@barnsley.gcsx.gov.uk as soon as possible and let us know what the nature of your agency's involvement with the adult at risk and their family was. This information is only required in brief at present – i.e. we are not asking you to write a full Internal Management Review of your agency's involvement at this stage. We are asking for this information in order to determine whether it is necessary to conduct a full Serious Adult Review and if so, which agencies need to be involved.

Please also confirm if your organisation has had no involvement with the family on the same template.

2. **Ensure any staff or volunteers who had contact with the people involved in the case are aware of the death, and that they have access to appropriate support.**

A decision will be taken on whether to go ahead with a full Serious Adult Review. We will be in touch again following that decision.

Please send your password protected response within 10 working days to ACAdultProtection@barnsley.gcsx.gov.uk and of course a separate password to enable access to the documents.

Yours sincerely

Chair of the DHR/SAR Executive Group

Appendix 3

This form should be completed when notifying Barnsley's Adult Safeguarding Single Point of Contact and the Chair of the Community Safety Partnership (CSP) that a Domestic Homicide Review/Serious Safeguarding incident has occurred. This form should be submitted within **48 hours** of a verbal referral to request that a DHR/SAR Executive Group is convened.

This form should be sent **by password protected e-mail (*marked confidential*)** to Barnsley's DHR Single Point of Contact via e-mail to ACAdultProtection@barnsley.gcsx.gov.uk

Notifier's details	
Name of person notifying	
Name of agency (if applicable)	
Designation (if applicable)	
Address of person notifying	
Telephone number of notifying person	
Email of notifying person	
Date of notification	
Victims details	
Victim's last name(s)	
Victim's first name(s)	
Other names used	
Victim's date of birth	
Age (if DoB not known)	
Date of death (if applicable)	
Home address	
Any other known addresses (please list):	
Ethnicity	
Preferred language	
Any disability	
Religion	
Are or were there any legal orders in place?	
Is the victim or has the victim ever been the subject of a Multi-agency Risk Assessment Conference (MARAC)?	

Brief summary of contact with the agency i.e. date span of contact/number of contacts and result of contact (NFA/Prosecution/Risk assessment not resulting in MARAC etc.)	
Alleged perpetrators details	
Perpetrators last name (s)	
Perpetrators first name(s)	
Other name(s) used	
Perpetrators date of birth	
Age (if DOB unknown)	
Home address	
Any other known addresses (please list):	
Ethnicity	
Preferred language	
Any disability	
Religion	
Are or were there any legal orders in place?	
Please state the current status of the police investigation if known. (Has the alleged perpetrator been arrested, place on bail or charged)?	
Is or has the alleged perpetrator ever been the subject of Multi-Agency Public Protection Arrangements (MAPPA)?	
Brief summary of contact with the agency i.e. date span of contact/number of contacts and result of contact (NFA/Prosecution/Risk assessment not resulting in MARAC etc.)	

Other members of the victims household – please provide details of any other members of the victims household?			
Name	**Date of birth**	**Address**	**Relationship to victim**

Details of incident	
Date of incident	
Address where incident occurred	
Please provide a brief overview of the circumstances of the case in the space below	

The criteria are met when:

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect; and one of the following:
- Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
- Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
- Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.

SAR criteria
Please highlight which of the criteria below has been met in order to convene a DHR/SAR Executive Group meeting? (Please put a cross in the applicable section)

An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death;	
An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect; and one of the following: • Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk; • Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time; • Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.	

Details of any agency known to or working with the victim			
Name	**Designation**	**Agency**	**Contact details**

Details of any agency known to or working with the alleged perpetrator			
Name	**Designation**	**Agency**	**Contact details**

Please return this form to BusinessSupportSafeguardingAdults@barnsley.gcsx.gov.uk within 48 hours of notification.

Appendix 3a

Chronology - confidential
Name of victim:

Please list the dates the victim were in contact with your agency (either in person through another source such as GP notes, files etc), the source of information, details about the nature of the contact and any comments.

Please ensure this is in date order without acronyms.

Victim chronology			
Dates	**Source**	**Nature**	**Comments**

Alleged perpetrator chronology			
Dates	**Source**	**Nature**	**Comments**

Appendix 4 – Invite letter to Executive Group

Dear colleague,

Re: Invitation to attend a DHR/SAR Executive Group Meeting in relation to (Insert name, date of birth and address of victim).

I am writing to inform you that an Executive Group meeting regarding the above named individual has been scheduled for (Insert time and date). The meeting will be held at (Insert location). **Please make a note of this date.**

Case Background:
(Insert brief summary from DHR Notification form).

Please bring along to the meeting any information you have in relation to this case. Note that a chronology of events has been compiled and will be used to inform the meeting.

Please confirm that you are able to attend.

Yours sincerely

Chair of the DHR/SAR Executive Group

Appendix 6 – Agenda template Executive Group

Agenda
Barnsley DHR/SAR Executive Group meeting

Insert Date
Insert Time
Insert Venue

1. Welcome and Introductions

2. Cases for consideration

   2a. Insert victim's name
   Overview of the circumstances which led to an agency referring this case for consideration of undertaking a Domestic Homicide Review/SAR.
   Information known to agencies.
   Identification of any investigations.
   Has the criteria for conducting a Domestic Homicide Review/SAR been met?

   2b. Insert victim's name
   Overview of the circumstances which led to an agency referring this case for consideration of undertaking a Domestic Homicide Review/SAR
   Information known to agencies.
   Identification of any investigations
   Has the criteria for conducting a Domestic Homicide Review/SAR been met?
   Agree on the recommendation to be forwarded to the Chair of Community Safety Partnership or Chair of the Safeguarding Board.

3. Any other business

Appendix 8 – Notifying family letter

Dear

Re:

I am writing to advise you that following on from (**Insert nature of incident**) a number of agencies in Barnsley will be taking part in a Safeguarding Adult Review of their involvement in the case in accordance with their duties under the Care Act 2014.

The purpose of such a Review is to establish whether there are lessons to be learned from the way in which local professionals and organisations worked together, with a view to improving service responses and inter-agency working in future.

I would very much like you to contribute to the Review and ask whether you would be willing to meet with me at a convenient local venue. This will be your opportunity to share your views on the way that agencies worked and the services that they provided.

If you would like to contribute to the review may I ask that you make contact with (**Insert contact**) on the above telephone number and the appropriate arrangements will be made?

If you have any queries please do not hesitate to contact (**Insert contact**) who is working with me on the review.

Yours sincerely

Appendix 9 – Individual Management Review Terms of Reference and Report Template

Barnsley Safeguarding Adults Board

Strictly Confidential
Please note Individual Management Reviews (IMRs) are confidential documents, which belong to the individual organisations and should not be shared with anybody outside of the SAR Review Panel.

Individual Management Review
For inclusion in
Barnsley Safeguarding Adults Board Safeguarding Adult Review Report

Relating to: Insert name of person to whom SAR relates

Author:

Contact details:

Date:

Report and Recommendations Ratified by:

Date:

Contents **Page No.**

1. Introduction
2. Terms of reference
3. Family Profile
4. Methodology
5. Chronology
6. Analysis
7. Lessons Learnt
8. Recommendation
9. Action Plan

1. Introduction

Provide an introduction to the case.

2. Terms of reference

These terms of reference are subject to review and updating as the SAR progresses.

The purpose of the SAR is to:

- Establish what lessons are to be learned from the death/serious incident of neglect or abuse regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent abuse or neglect and improve service responses for all adults at risk through improved intra and inter-agency working.
- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of abuse or neglect.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Reduce the risk of abuse or neglect and improve service responses through improved intra and inter-agency working.
- Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the serious incident.

The Terms of Reference that will be addressed in the Individual Management Reviews are:

a. To review each agency's involvement with the following people between the following dates - from **INSERT DATE** to **INSERT DATE**.

- Victim's name, Date of birth and Date of death (if applicable)
- Address

- Alleged perpetrator's name and Date of birth
- Address

- Children
- Address
- Further address identified

Agencies with relevant knowledge of the victim or perpetrator before this time are asked to provide a brief synopsis of their involvement.

The review will address:

a. Whether the incident was a 'one off' or whether more could have been done to prevent the abuse or neglect from occurring.
b. Whether there were any barriers experienced by the adult at risk or family / friends / colleagues in reporting abuse, including whether they knew how to report their concerns.
c. Whether the adult at risk had experienced abuse or neglect previously in Barnsley or elsewhere.
d. Whether professionals missed opportunities for professionals to identify and deal with the abuse at an earlier stage.
e. Whether the alleged perpetrator had any previous history of abusive behaviour and whether this was known to any agencies.
f. Effectiveness of partnership working and information sharing in relation to the adult at risk and the alleged perpetrator.
g. Any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of safeguarding adults in the borough.
h. Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator, e.g. age, disability, ethnicity, religion and belief, sexual orientation.

Questions to be covered in the IMR

The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.. The following are examples of the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for abuse victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?
- Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Was anything known about the perpetrator? For example, were they being managed under MAPPA?
- Had the victim disclosed to anyone and if so, was the response appropriate?

- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity and sexual orientation of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the death/serious incident have been accurately predicted and prevented?

3. Family Profile

Provide details of the family profile.

4. Methodology

Please record the methodology used including extent of document review and interviews undertaken.

5. Chronology

Construct a comprehensive chronology of involvement by agencies over the period of time set out in the Terms of Reference. State when the victim/perpetrator/family member was seen including antecedent history where relevant. ***Please do not include full names or addresses in this section.*** Identify the details of the professionals from within your agency who were involved with the victim, perpetrator, family and whether they were interviewed or not for the purposes of this IMR. **Please do not refer to workers by name. For clarity use SW1, SW2 for social workers and HV1, HV2 for health visitors etc. For confidentiality reasons there is a table in the appendices for codes used which will be removed prior to circulation.**

Source of information: State whether information from interview with staff, case notes, supervision notes etc.
Subject of recording: Using initials only state who the entry relates to i.e. deceased, suspect, parent, sibling, child etc.

Template to be used for the chronology:

Chronology - confidential

Name of victim:

Please list the dates the victim was in contact with your agency (either in person through another source such as GP notes, files etc), the source of information, details about the nature of the contact and any comments.

Please ensure this is in date order without acronyms.

Victim Chronology				
Dates	**Source of information**	**Subject of recording**	**Nature of information**	**Comments**

Perpetrator Chronology				
Dates	**Source of information**	**Subject of recording**	**Nature of information**	**Comments**

6. Analysis

Consider the events that occurred, the decisions made and the actions taken or not. Assess practice against guidance and relevant legislation. Please consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above, using the Terms of Reference headings.

7. Lessons Learnt

Consider both the practice that occurred, including any good practice and areas for improvement.

8. Recommendation

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking. These will be used to develop the action plan.

9. Action Plan

Actions should be Specific, Measurable, Achievable, Realistic, Timely, Evaluation, Review (SMARTER)

Appendix 10 – Checklist for an excellent IMR

Barnsley
Checklist for an excellent IMR
January 2016

1	The agency identified a suitably independent author to complete the IMR and this is clearly stated in the IMR	
2	The IMR author has provided an overview of the role of the agency	
3	The IMR author has provided a brief summary of their background and suitability to complete this IMR	
4	The IMR follows the template provided by Barnsley Community safety Partnership and is fully anonymised using the codes provided. Professionals should be identified by their job title and a list provided as a separate appendix	
5	The Terms of Reference are clearly set out and each Term of Reference answered if applicable to the agency	
6	The IMR sets out which records were accessed	
7	All relevant staff have been interviewed and where this has not been possible this has been fully explained in the IMR	
8	The IMR has retained a focus on the people concerned and the victim's voice comes through in the IMR	
9	The IMR has addressed issues of race, culture, language, religion and disability	
10	The IMR is well structured, comprehensive, and analytical and looks openly and critically at practice, decisions made, and services offered to the homicide victim, perpetrator, and/or members of their family(ies) or household(s. Good practice is identified	
11	The IMR reaches well founded conclusions and identifies the key lessons to be learnt	
12	The recommendations flow from the lessons learnt and are SMART (specific, measurable, achievable, realistic and timely). There are recommendations on how to evaluate the impact and review the implementation.	
13	The IMR has been signed off by a Senior Manager in the agency	
14	There is a clear plan of how the findings will be fed back to the staff members involved.	