BARNSLEY SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review Protocol

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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

2. What is a Safeguarding Adult Review?

2.1 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 because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2,2 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.

2.3 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) because of the abuse or neglect.

2.4 SABs may arrange for a SAR in any other situations involving an adult in its area with care and support needs, whether 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.

2.5 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 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.

2.6 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.

2.7 SABs are required to cooperate with Safeguarding Adults Reviews with other SAB's and if necessary, share the costs, if the adult was placed in the area by organisations in the Barnsley area, as set out in the Y&H ADASS SAR protocol.

2.8 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?

3.1 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.

3.2 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.

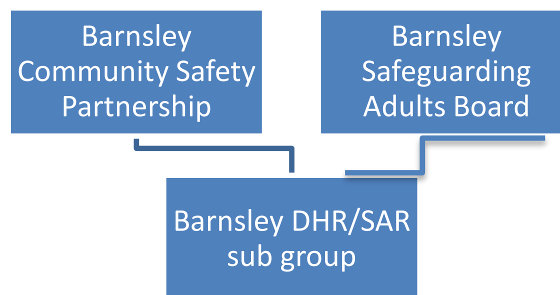
4 Who has responsibility for commissioning a SAR.

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

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

4.3 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 and reports back to the respective Board(s).



5 Notification of a potential Safeguarding Adults Review

5.1 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 Safeguardingadultsservice@barnsley.gov.uk using the SAR request form – https://www.barnsley.gov.uk/services/children-young-people-and-families/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers-who-safeguard-adults/ request a SAR.

5.2 The request should be considered against the criteria for a SAR process and recorded in the SAR minutes and on the BSAB tracking system. Individual organisations should record on appropriate systems in line with their SAR protocols.

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

5.3 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: Safeguardingadultsservice@barnsely.gov.uk

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

5.5 Links with other reviews and investigations

BSAB will work cooperatively with other review processes, when appropriate to maximise learning and reduce duplication, this may include.

- Domestic Abuse Related Deaths (DHRs)
- Suicide reviews
- Drug and Alcohol Death Reviews
- LeDeR reviews
- Local Safeguarding Children's Practice Reviews
- PSIRF (Patient Safety Incident Reporting Framework)
- Other

5.6 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

6.1 In Barnsley the consideration of whether to undertake a SAR is delegated to an Executive Group of the Barnsley CSP/SAB. The panel is chaired by a partner agency and reports to both the Independent Chair of BSAB and the BSAB meeting by a highlight report.

6.2 Aim of the Executive Group

- To share historical and current agency information known about the adult and their circumstances to establish if the SAR criteria are met.
- To share information about the events surrounding the death of the adult.
- To identify any parallel review processes which may be planned or underway in relation to the incident, and the implications of these for 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 and make recommendations about the format of the review.
- To identify those best placed to sit on the Safeguarding Adult Review Panel (where applicable) and its terms of reference.

6.3 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.

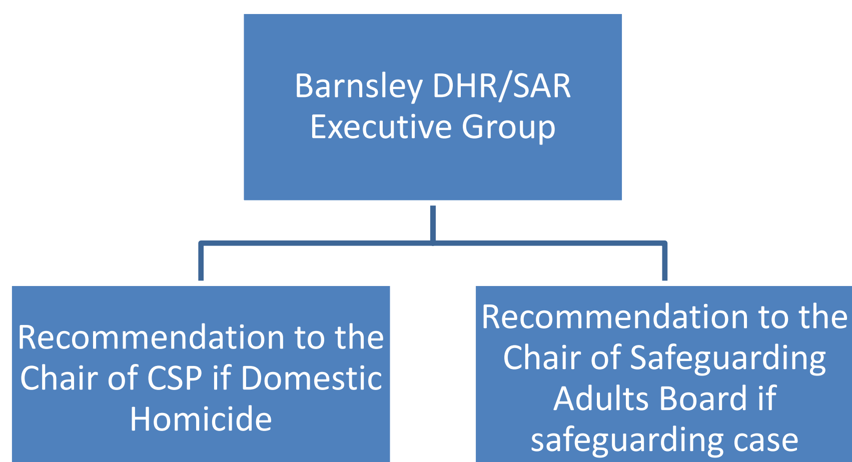
6.4 Membership

Core membership of the Executive Group comprises of:

- Barnsley Council services including Adult Social Care, Safer Communities, Healthier Communities, Safeguarding Adults
- South Yorkshire Police.
- Barnsley Place (ICB)
- South West Yorkshire Foundation Trust.
- National Probation Service
- Barnsley Hospital Trust (BHNFT)
- Berneslai Homes

Any other local or national agency which had or may have been involved with the adult, 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



6.5 Servicing the meeting.

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Executive Group meetings will be serviced by BSAB business support for SAR, 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 adult. 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 been involved with the adult, 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.
- Prepare agenda as set out in **Appendix 6**.
- Attend the meeting, take minutes, and produce an action log.
- 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 Equalities Duty

7.1 The SAR panel will comply with the Equality Act duties and record protected characteristics as part of any statutory or other review.

7,2 Section 4 of the Equality Act 2010 defines protected characteristics as:

- age [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties.” However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- disability [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer can lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy

everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].

- gender reassignment [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- marriage and civil partnership [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- pregnancy and maternity
- race [for example colour includes being black or white. Nationality includes being a British, Australian, or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- religion or belief [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- sex
- sexual orientation [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

7.3 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] the impairment has a substantial and long-term adverse effect on P's ability to conduct normal day-to-day activities[7].

[7] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

8 Decision to Conduct a Safeguarding Adult Review

8.1 The decision on whether to hold a SAR will be made by the SAR subgroup and endorsed by both the Chairs of the SAR subgroup and the Independent BSAB chair. The draft Terms of Reference for the SAR will be approved by SAR subgroup and the BSAB chair.

8.2 Barnsley's Safeguarding Adults Board Manager, on behalf of the SAB Chair, must inform the adult's family and/or friends, in writing, of the SABs decision to complete a SAR, non-statutory SAR or no further action.

8.3 If the family disagree with the decision reached by the panel, the Executive members of BSAB (Chair, South Yorkshire Police, ICB and Place Director in Barnsley Council will review the decision within 28 days of the appeal being received

9. Conducting the review

Following a decision the following will be agreed:

9.1 Terms of reference

The Chair and members of the DHR/SAR Executive Group will be responsible for recommending a SAR methodology, preparing draft Terms of Reference, and agreeing a process for recruiting an independent chair, if required.

9.2 Appointment and Role of the Report Author

The SAR panel will identify if an independent author is required and produce a draft term of reference to share with potential authors. A recruitment process will be agreed on a case-by-case basis.

Consideration of an author who is employed by a partner organisation that did not have contact with the individual will be considered to

- avoid delay in completing the SAR.
- Include local knowledge of services and politics.
- Produce an action plan that reflects local priorities.

The author will be expected to provide updates to the SAR panel, consult with family and friends and present the final report to BSAB.

10. Individual Management Reviews (IMRs)

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

10.2 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.

10.3 Full names and designations of individuals will be used in reports submitted to the Review Panel. Every IMR should be accompanied by a detailed chronology of agency involvement with the individuals subject to a SAR.

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

10.5 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.

10.6 Those conducting Individual Management Reviews should consider carefully whether interviews with staff and volunteers are required and what information will be sought from these. Advice should be sought from senior managers and the Police Senior Investigating Officer if a criminal enquiry is taking place.

10.7 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.

10.8 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.

10.9 The IMR reports should be quality assured by a senior manager in the organisation on behalf of the Chief Officer and communicated, in writing, to the SAR panel.

11. Timescales for Conducting a Safeguarding Adult Review

11.1 The SAB will aim for completion of a SAR within six months of agreeing a SAR is required, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings.

11.2 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.

11.3 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.

11.4 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.

11.5 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.

11.6 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.

12. Disclosure and Criminal Proceedings

12.1 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.

12.2 Material generated or obtained during 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 consult 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.

12.3 It is the responsibility of the Disclosure Officer to consult 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.

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

13.1 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 and their networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances, for example, the contributor is implicated in the abuse or neglect.

13.2 The benefits include:

- Assisting the family with the healing process and allows to reflect on the support provided to their loved one.
- Helping families satisfy the often expressed need to contribute to the prevention of other deaths or cases of serious harm.
- Allowing the Review Panel to get a more complete view of the adult's life and see the circumstances through the eyes of the adult and help the panel to understand the choices the adult 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.

13.3 The Review Panel must ensure that family members and other people involved in the review are updated on the progress of the review and the outcomes.

13.4 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 collaborating with the Police Family Liaison Officer and Senior Investigating Officer involved in any related police investigation, if applicable.

14. The Report

14.1 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.

14.2 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.

14.3 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.

14.4 An Executive Summary of the Report and /or learning brief should be prepared by the Report Author, unless agreed otherwise.

14.5 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 adult, any perpetrator, and the home circumstances of the adult.

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 practice this 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 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 have approved the report to evidence 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 for discussion and sign off by the full BSAB.
The report published in full or summary on the safeguarding adult's webpage and shared with the national SAR library.

15. Action plans

15.1 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.

15.2 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.

15.3 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 have influence on practice.

15.4 Any delay in completing actions will be escalated up to BSAB and the Independent Chair.

16 Findings from Safeguarding Adult Reviews

16.1 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.

16.2 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.

16.3 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 Safeguarding Adults Reviews

16.1 The value of Safeguarding Adult Reviews is in the learning derived from them. Focus must be given to embedding the recommendations into practice and evaluating the impact of any agreed changes.

16.2 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.
- Identify any system changes required.
- 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 for improvement.
- Focus recommendations on key areas with specific and achievable proposals for change and intended outcomes.
- Ensure robust monitoring of the agreed Action Plan embeds learning in practice.
- 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 is expected from them if they engage in a SAR.

Appendix 1 – Flow Chart

Safeguarding Adult Review Process

STAGE ONE

Step 1 – Initial notification

Notification to single point of contact (SPC) at safeguardingadultsservice@barnsley.gov.uk for SAR

Step 2 – Informing key stakeholders

SPC notifies:
SAB Chair
Executive Director People as appropriate
Services Director Communities
Services Director (Adults)

Within 24 hours

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

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 SAR Executive meeting – within 30 working days
3d. SPC pulls together information for the SAR panel

Step 4 – Decision making

4a- All members of SAR will review information circulated in advance of the meeting
4b – Decision reached, and the SAR decision sheet is completed
4c – Decision communicated to BSAB chair and BSAB

Appendix 2 – Letter requesting information.

Dear Colleague

URGENT: SAFEGUARDING ADULT REVIEW

An incident has taken place that may require a Safeguarding 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 adult: 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 Safeguarding Adults Review/DHR panel to inform discussions about the need for a Safeguarding Adult Review.

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 safeguardingadultsservice@barnsley.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. At this stage we require a summary, i.e. we are not asking you to write a full Internal Management Review of your agency's involvement. This information will support decision making about whether a statutory SAR or other review is required, and which agencies need to be involved.

Please also confirm if your organisation was not involved with the adult 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 Statutory/non statutory safeguarding Adult Review. We will be in touch again following that decision.

Please send your password protected response within 10 working days to safeguardingadultsservice@barnsley.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 – Notification

This form should be completed when notifying BSAB that a safeguarding adults safeguarding review may be required. This form should be submitted within **48 hours** of becoming aware of the possible need for a SAR.

This form should be sent **by secure email to** safeguardingadultsservice@barnsley.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 persons	
Email of notifying person	
Date of notification	
Adult's details	
Adult's last name(s)	
Adult's first name(s)	
Other names used	
Adult'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?	
Summary of contact with the agency i.e. date span of contact/number of contacts and result of contact (NFA/ Assessment and service provided, referral to other service, other etc.)	
Alleged perpetrators details – if applicable	
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?	

Other members of the adult's household – please provide details of any other members of the adult's household?			
Name	**Date of birth**	**Address**	**Relationship to Adult**

Details of incident	
Date of incident	
Address where incident occurred if different from home address	
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 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 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 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 adult			
Name	**Designation**	**Agency**	**Contact details**

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

Appendix 3a

Chronology - confidential
Name of Adult:

Please list the dates the Adult 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.

Adult chronology			
Dates	**Source**	**Nature**	**Comments**

Alleged perpetrator chronology – if applicable. If not leave blank			
Dates	**Source**	**Nature**	**Comments**

Appendix 4 – Invite letter to SAR panel (non -standing members)

Dear colleague,

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

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

Case Background:
Insert summary from Appendix 3
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 can attend.

Yours sincerely

Chair of the DHR/SAR Executive Group

Appendix 5
SAR Decision Checklist

Name	
Dob and date of death – if applicable	
Protected characteristics – if any	
Cause of death – if known	
Date of decision	

SAR Criteria

Criteria	Yes	No
• 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 apply		
• 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 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/adult at risk		

Decision making

Option	Decision
Statutory SAR	
Non-Statutory SAR	
Joint review – more than one organisation	
Single agency review	
Referral to another process – LeDeR, DARD, Suicide etc	
No Further Action	
Date of decision	
Unanimous or majority decision	

Appendix 6 – Notifying family letter (this may be amended to meet the needs of the family/case)

Dear

Re:

I am writing to advise you that following referral and a decision by the safeguarding adults review subgroup on the (**Insert nature of meeting**) several 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 contact (**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 7 - IMR template – to be agreed for each case.

1. **Introduction**
   Introduce 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 adults.
- 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 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 adults 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 Adult, prior to the serious incident.

The Terms of Reference will inform the content of the Individual Management Reviews and include:

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

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

- Further address identified.

Agencies with relevant knowledge of the adult 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. Consider any equality and diversity issues that appear pertinent to the adult or perpetrator, e.g. age, disability, ethnicity, religion and belief, sexual orientation.

Possible questions for the IMR

The review should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements made or actions taken that indicate that practice or management need to improve, the review should consider not only what happened but why. The following are examples of the areas for consideration:

- Were practitioners sensitive to the needs of the adult and the perpetrator, knowledgeable about potential indicators of abuse and aware of what to do if they had concerns about an adult 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 for the adult and/ or perpetrators and were those assessments correctly used in the case of this adult.
- What were the key points or opportunities for assessment and decision making in this case? Do the assessments and decisions evidence good practice and professional competence?
- 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 adults wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the adult should have been known? Was the adult informed of options/choices to make informed decisions? Were they signposted to other agencies?
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity and sexual orientation of the adult 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?
- Can we share more effective working methods across organisations or individuals.
- Can we learn lessons about individual and joint working to keep adults safe and evaluate their ability to identify, assess and manage risk of harm and abuse? Can we improve practice? 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 adult and perpetrator?
- To what degree could organisations/workers have identified and prevented the risk of death/serious incident?

3. Family/Friends Profile

Provide details of the family/Friends' 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 set out in the Terms of Reference. List contact and the nature of that contact (phone, letter, in person etc.) with the adult/perpetrator/family member including antecedent history where relevant. **Please do not refer to workers by name. For clarity use SW1, SW2 for social workers and HV1, HV2 for health visitors etc.**
Source of information: State whether information from interview with staff, case notes, supervision notes.
Subject of recording: Using initials only state who the entry relates to i.e. subject of the SAR, parent, sibling, child.

Template to be used for the chronology:

Chronology - confidential

Name of adult:

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

Please ensure this is in date order without acronyms.

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

Perpetrator Chronology – if applicable

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 in line with the terms of reference.

7. Lessons Learnt

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

8. Recommendation

Recommendations should focus on the key findings of the IMR and be specific about the outcome which they are seeking. The combined recommendations will inform the final action plan, and the SAR subgroup will monitor progress.

9. Action Plan

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