Coventry Safeguarding Adults Board

Safeguarding Adults Review

Toolkit

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Safeguarding Adults Reviews (SARs)

The Care Act 2014 introduces statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews), and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

1. Criteria

Criteria from s44 of the Care Act 2014:

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

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

(2) Condition 1 is met if—

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

(3) Condition 2 is met if—

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

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

* the adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

2. Purpose

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently, so that they could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

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

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs, their response will be defensive and their participation guarded and partial.

3. Principles

The following principles apply to all reviews:

- 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;

- the individual (where able) and their 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;

- the SAB is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;

- 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 and

- professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.

- the judgement should make meaningful reference to the principles of Making Safeguarding Personal and the six core safeguarding principles.

1. Referral Process to the Safeguarding Adult Review Subgroup

The Coventry SAR referral form (Appendix 3) must be completed and submitted to the SAR subgroup before a case can be considered for review within the SAR process. The completed form explains why the referrer considers that the case meets the threshold for a SAR. All referral forms must have been approved by the referrers' line manager before submission to SAR subgroup for consideration

The referral form needs to be securely return to the Safeguarding Board, via the following email account CoventrySAB@coventry.gov.uk

If the referrer does not have access to a secure email account to send the form, they should contact the Safeguarding Board Support Team by telephone 02476975477 to agree an alternative secure submission.

An email acknowledgement of the referral will be returned within two working days. The SAB Business Manager will contact the referrer within 3 working days to discuss the case, this will inform the decision to progress the referral for consideration by the SAR subgroup. The SAB Business Manager is responsible for notifying the referrer of the decision made. The SAB Business Manager will where possible identify and invite the most appropriate professional to attend the SAR subgroup and discuss the case.

If the SAR subgroup decides that a SAR is not required, they will consider and identify whether an alternative review or process should be undertaken.

5. The Decision-Making Process for a Safeguarding Adult Review

5.1 The Decision-Making Process

The first scheduled SAR subgroup post receipt of the referral will consider the case and make the decision to request additional information (scoping) from other partner agencies involved. SAB Business Manager will send the Coventry Safeguarding Adult Review scoping letter (Appendix 4) to all the relevant partner agencies who are likely to have had contact or provided services for the adult(s) at risk in this case review. The agencies will be requested to complete this proforma and return it to the Coventry Safeguarding Board Support team, within 4 weeks The SAR will collate the information to present to the SAR subgroup members to assist them with the decision making process.

The SAB Business Manager will inform the Independent Chair of the CSAB and (out of courtesy) the Director of Adult Services.

An extra-ordinary SAR will be convened if required due to the nature of the case being considered and/or the length of time until the next SAR subgroup meeting.

The group will be asked to identify if there is any conflict of interest when determining the decision and the SAR Subgroup will take this into account.

In any case for members to reach a decision to proceed with the recommendation to undertake a SAR, there must be representation at the meeting from the statutory partners. The meeting will also be minuted to ensure that there is a record of the decision-making process. The decision to undertake a SAR is made by the Independent Chair of the CSAB, and it is the responsibility of the chair to advise the Director of Adult Services of this decision.

5.2 Local Approach to a SAR

Once a decision has been made to conduct a SAR, agencies should secure records at the earliest opportunity, to ensure the integrity of the documentation. In reference to accessing patient medical information from a general practice see Appendix 8

The SAR subgroup can make recommendations as to how the SAR should be approached or this decision can be left for the panel to decide. In either

case the decision is based on the SAR subgroup's consideration of each specific case.

The SAR subgroup will commission a Review Panel which is representative of the partner agencies involved and the complexity of the case.

An independent chair and author will also be appointed by CSAB to facilitate the panel process and to write the overview learning report. The administrative support to the panel process is provided by the Safeguarding Board business support team.

The Review Panel* in conjunction with the SAR subgroup are responsible for the following:

- Agreeing the methodology to be used. This decision will be based on which method will deliver the required learning to support improvements in practice and or services.
- Developing the terms of reference for the review, which will include the time frame for completing the process, which will aim to be within a 6-month period unless there are extenuating circumstances.
- The chair or author of the review panel will notify the SAR subgroup if they predict that there will be a delay in completing the review within the agreed time frame.

*The panel includes the independent chair and author as members

6. SAR Methodologies

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. Methodology is not prescribed in the Care Act 2014 and this enables flexibility to consider a range of options. No one model or methodology will be applicable for all cases, the SAB will need to weigh up what type of 'review' process is proportionate to the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The ultimate decision to arrange a SAR is the responsibility of the Chair of the SAB.

The focus must be on what needs to happen to achieve an understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another.

6.1 Traditional Serious Case Review model

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

<u>This model includes</u>

- the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
- appointment of an Independent Report Author to write the overview report and summary report
- involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning
- chronologies of events
- formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships
- publishing the report in full.

The benefits of this model are:

- it is likely to be familiar to partners
- possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- methodology stems from children's arena so process to adults is not so familiar
- resource intensive
- costly
- can sometimes be perceived as punitive and
- does not always facilitate frontline practitioner input.

6.2 Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes :(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author

- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- cost effective
- Enhances partnership working and collaborative problem solving
- Encompasses frontline staff involvement
- Learning takes place through the process enhancing learning.

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

6.3 Individual Agency Review

This model would be relevant when a serious incident or near miss identifies just one agency being involved or one agency who may need to learn from the situation and there are no implications or concerns regarding involvement of other agencies.

Such reviews undertaken under the SAR process should always be instigated and scrutinised by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking an Individual Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships. Where instigated by the SAB, any recommendations should be considered by the SAB.

Circumstances when this model might be appropriate:

- Serious Incidents
- Implications relate to an individual agency, but lessons could be shared, applied and learnt across the partnership
- Where serious harm and/or abuse was likely to occur, but had been prevented by good practice (positive learning)

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The benefits of this model are:

- Provides an opportunity for learning from an individual agency
- Enables individual agency scrutiny into a specific area

- Assists in implementing 'Duty of Candour'
- Cost effective and proportionate

The drawbacks of this model are:

- Can be seen as outside the SAR purpose of multi-agency learning
- Rely on individual agency to scrutinise the incident without a multiagency perspective

It is accepted that this is already part of the national Serious Incident Reporting Framework (SIRI) in health settings. Where necessary final reports of SIRI's will be reviewed by the board.

6.4 Peer review approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasingly used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- Peers can be identified from SAB Board members or
- Peers could be sourced from another area/SAB which could be developed as part of regional, reciprocal arrangements

The benefits of this model are:

- Increased learning and ownership if peers are from the SAB
- Objective, independent perspective
- Can be part of reciprocal arrangements across/between partnerships
- Cost effective and proportionate

The drawbacks of this model are:

- Capacity issues within partner agencies may restrict availability and responsiveness
- Skill and experience issues if SARs are infrequent
- Potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

6.5 Significant event analysis/audit (SEA)

SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward

incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it. NHS England has published a Serious Incident Framework in March 2015

The benefits of this model are:

- It is not a new technique – doctors have long discussed cases for educational and professional purposes.
- Cost effective and proportionate

The drawbacks of this model are:

- Seen as a model that relates only to Health.

6.6 Case file audit (multi or single agency, tabletop or interactive)

Case file audit can be a powerful driver in improving the quality of front-line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.
They can be undertaken in a number of ways:

- As a table-top exercise (therefore no input from practitioners)
- Interactive with partners and or practitioners.
- Interactive with the adult and or their family.
- Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- Flexible – in that they can be conducted in many different ways.
- Quicker learning can be achieved.
- Cost effective and proportionate

The drawbacks of this model are:

- There may be limits to learning from sole examination of paper records.
- Due to the timescales it can be more difficult to engage the family as they may have suffered loss/ trauma very recently.

6.7 Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors, the root causes of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes
- To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence
- There is usually more than one potential root cause of a problem
- To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS
- Focus is on the root cause and not on apportioning blame or fault
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

6.8 Rapid learning review

This type of review may be useful when either a lighter touch is needed, there needs to be further exploration of some areas or where it is important that the SAB extracts the learning quickly.

The aim of this type of review is that it is completed within one calendar month. When this methodology is agreed agencies will be sent out scoping documents asking them to identify a brief chronology of their agencies contact with the individual/s as well as an analysis of their practice. A Rapid Learning Review meeting will be convened, Chaired by the Independent Chair, which will provide an opportunity to agencies to identify key themes and areas for improvement.

The benefits of this model are:

- It allows learning to be quickly identified.
- It is less resource intensive than other reviews

The drawbacks of this model are:

- It may have less detail than other types of reviews

7. Learning events

Agencies may be invited to event for the purpose of supporting the safeguarding system to learn. Learning events can be useful at 3 stages:

- As part of the SAR methodology
- After a SAR to share findings
- After a SAR to evaluate the impact of implementing the recommendations.

8. Duty of Candour

All members of a SAB are required to have a culture of openness, transparency and candour within their day to day work and with the SAB. In interpreting this "duty of candour", we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

- *Openness* – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- *Transparency* – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- *Candour* – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice, as members of the SAB, all agencies have a responsibility to ensure they are open and transparent with the SAB when incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incidents that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying both their own learning and multi-agency learning.

8. Roles and responsibilities of the SAB

Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for:

- Arranging Safeguarding Adults Reviews (SARs)
- Ensuring the SAR is completed in a reasonable time
- Ensuring there is appropriate involvement in the review process of professionals and organisations who were involved with the adult.
- Ensuring the adult or their family is not only communicated with but involved in the review where possible
- Receiving the recommendations
- Agreeing an action plan
- Ensuring the recommendations and action plan are implemented
- Publishing information about SARs in the Annual Report including what recommendations have and have not been accepted

i) *Independent Chair of the Coventry Safeguarding Adult Board*
The Independent Chair of CSAB is responsible for the decision to undertake a SAR in response to the SAR Subgroup recommendations.

The Independent chair is responsible for providing regular updates on the progress of any SARs to the Safeguarding Adult Board.

ii) *Coventry Safeguarding Adult Board members*
It is the responsibility of the CSAB members to nominate experienced, senior staff from their organisation to participate in SARs. These staff should be

supported by their agency's senior manager responsible for the delivery of this agenda within the respective organisation. They should not have been directly involved in the case under review.

Due to the time consuming and complex nature of this process all the members are responsible for discussing progress with their nominated learning report author. They are also expected to provide these staff with the support and guidance they may require to construct a report which meets the CSAB quality standards, recognising that providing them with the protected time to complete the review should be a prerequisite of their nomination.

The members of CSAB are responsible for the monitoring and the implementation of their organisation's actions within the multi-agency plan. Members will be expected to provide CSAB with the evidence that their actions have been delivered to plan.

iv) *CSAB SAR Subgroup*

SAR Subgroup is responsible for making the recommendation to the CSAB Independent Chair when they consider a case meets the criteria for a SAR, this recommendation can only be made by the SAR subgroup. The final decision to undertake a SAR is made by the CSAB Independent Chair.

Where the case is agreed as meeting the criteria for a SAR, the SAR subgroup will make recommendations relating to preferred overall approach applied to the SAR, or delegate this solely to the Review Panel.

The approach to be taken to ensure engagement with the adult at risk, family members and person(s) or organisations is agreed by the SAR Subgroup and their recommended approach is presented to the CSAB Independent Chair to approve.

The SAR subgroup is responsible for the on-going performance management of the SAR process and for providing progress updates as a standing agenda item to each CSAB meeting. The Safeguarding Adult and Children Board business support team is responsible for providing the operational and administration support function to both SAR subgroup and CSAB.

v) *Safeguarding Adult and Children Board business support team*

The responsibility of this team is to provide an operational and administration support function to the SAR process. The team members providing the support for a SAR are as follows:

Joint Safeguarding Board Business Manager – is responsible for all aspects of the business management relating to CSAB. The Boards Business manager will take responsibility for the coordination of all aspects of the SAR process, including the management of the timeline for key meetings, report submissions and progress updates to CSAB and SAR subgroup and also provides the central point of contact for the SAR Independent author and chair, agency report authors, panel members.

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Boards Business Manager Administration Support Officers – provide the overarching administration support to the SAR process, working closely with the Boards Business Manager

- vi) Independent[1] Chair for the SAR

The Independent Chair is commissioned by the SAR subgroup. They will be appointed in relation to their knowledge, experience and skill to undertake this complex and challenging role as set out in the contract agreement (Appendix 5b).

The Chair is accountable to the SAR subgroup chair providing regular progress updates. The chair will also be expected to achieve a consensus with the panel members in respect of the key areas for learning and improvement.

In line with CSAB aspiration, the SAR chair will provide all of those involved in the process with an opportunity to positively reflect on events and to learn and develop as a result of the review. The process should be managed without prejudice, focusing primarily on the positive but recognising that had events been managed differently, the outcome may have been different.

All the partner agencies involved must also be kept up to date by the SAR Chair with the progress and any relevant learning that has been achieved in the process of the review. The SAR Chair in conjunction with the independent author is responsible for presenting the final overview report to the CSAB for consideration and endorsement by the Board.

vii) *SAR Independent Author*

An Independent SAR author will be commissioned by the SAR subgroup.

The role of the independent author is to work in collaboration with all the partner agencies involved in the SAR to ensure that all of the issues raised within the terms of reference have been critically analysed and addressed through the review process. The independent author is responsible for producing an overview report which includes the recommendations which have been agreed with the SAR Panel members. The recommendations must deliver positive learning to support improvements in practice and services across Coventry.

The independent author in conjunction with the SAR Chair is responsible for presenting the final overview report to the CSAB for consideration and endorsement by the Board.

viii) Safeguarding Review Panel members

SAR panel members are in most instances nominated by their agency's SAR subgroup representative, but this can also be the subgroup member. The panel member must be a senior manager who has no line management responsibility or previous connection with the case. The panel member must be sufficiently senior and experienced to be able to effect sustainable change

[1] Independent in this context, refers to an individual is has no prior knowledge of the case.

in their organisation and be able to work with the other panel members to influence change and improvement across the wider partnership.

The individual agency panel member should provide support and guidance to their nominated learning report author, these two roles provide separate functions within the SAR process, therefore, the SAR subgroup recommends that the participating agency should nominate two individuals.

Where the panel has been delegated by the SAR subgroup they will recommend which methodology and provide details of the approach including terms of reference and the time frame.

The SAR panel members are all individually responsible for providing accurate and timely feedback to their organisation SAB member relating to the SAR progress or issues which may need immediate intervention at a senior level.

ix) *Learning Report Authors/ senior management oversight and sign off*

The learning report author (LRA) is nominated by their organisation to produce a learning focused report. They will have had no previous involvement or connection with case, but they will have had some experience at writing objective reports. They need to have knowledge of professional standards and be familiar with current research in relation to evidence based practice.

The learning report author will have access to mentorship and support throughout the process. While LRA is responsible for their report the accountability for authorising, the report sits with senior manager or the organisation's executive lead. The authorisation process also requires that the accountable signatory quality assures the report before it is submitted to the independent author.

The LRA is responsible for completing the chronology of events (Appendix 6) based on agency's involvement in the case. The information needs to remain brief and concise.

In preparation for writing the learning report the LRA needs to familiarise themself with local policies and procedures including any relevant partnership policies and procedures, these will be used to cross reference events against the relevant policy or procedure guidance. Where the LRA feels that additional specialist or specific information is required they will interview the relevant staff members to clarify these points.

Interviewing staff

Interviewing the staff members needs to be managed with sensitivity allowing the interviewee to be accompanied if they wish, and to make it clear the purpose of the interview is not to apportion any blame, but to fully understand the events so that practice improvement and learning can be made. A documentary record of the interview should be taken and shared with the interviewee and any others present. Staff members should not however be interviewed if to do so compromises any ongoing police investigation.

The LRA is responsible for collating and analysing all the information gathered during their preparation. A report including the recommendations will be produced (appendix 7) which includes the details of this desk-based review and the interviews.

iix) *Adult(s) at Risk, Family and Significant Others*

These individuals provide a vital contribution to the intelligence gathering process. This is an integral component of the review process which needs to be handled sensitively if it is to be of mutual value to all involved. The SAR subgroup will nominate a member(s) to offer a meeting with the relevant individuals to explain the SAR process and to provide an opportunity for them to share their views. This meeting can also be used to signpost these individuals to other sources of support and advice which they may need as a consequence of their experience. Partners meeting adults at risk may wish to share the 'Information for individuals' (Appendix 6).

The SAR subgroup will keep these individuals regularly updated of progress. When the SAR reaches its conclusion and been approved by the Independent Chair of CSAB, the chair will offer to meet with these individuals to discuss and explain the conclusions of the review.

9. Learning across the region

The West Midlands Region is committed to sharing learning from Safeguarding Adult Reviews so that lessons can be learnt and action taken to prevent and protect adults with care and support needs.

A West Midlands Regional SAR databank will be set up for the notification and keeping of all SARs carried out in the West Midlands region.

Each SAB will:

- Notify the West Midlands Regional SAR databank when a SAR is commissioned
- Inform the West Midlands Regional SAR databank when a SAR is completed
- Provide the West Midlands Regional SAR databank with information to enable regional learning
- Make available a copy of the SAR report for posting on the West Midlands Regional SAR databank

10. Resolving disagreements

It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is outside the provider's area. If that is the case, a SAR should be carried out by the Board that is responsible for the location where the serious incident took place. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

Safeguarding Adults Boards can co-commission a SAR and can negotiate

who should take the lead which will be determined by the individual case.

If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the Chair of the Safeguarding Adult Board/s. If agreement can still not be reached this should be escalated to the Local Authority Chief Executives.

As a last resort a complaint can be made to the Local Government Ombudsman (LGO) if the complainant:

- disagrees with SAB decision to not undertake a Safeguarding Adult Review
- Has concerns regarding the decision of a SAB or outcome of a Safeguarding Adult Review
- Has concerns about the makeup of the SAR and potential conflict of interest
- is concerned the Chair of the SAB is also the chair of the SAR
- is unhappy with the conduct of a professional on a SAB who is employed by a body that falls outside the LGO's jurisdiction.

11. Governance

Due to the complexity and the sensitive nature of the SAR process it is essential that they are managed within an explicit governance framework.

11.1 Governance Reporting Framework

- Each agency will be responsible for taking the report through it's own governance structure.

- For the CSAB the report will go through the following governance for sign off:

1 SAR panel

2 SAR sub group

3 Business Executive Group

4 Coventry Safeguarding Adult Board

12. The SAR Checklist

Whichever model/approach used there are a number of key considerations. This framework has been developed to help to decide the most effective and efficient way to identify learning for families, organisations and the Board. Some of the elements below are mandatory and others are optional.

Terms of Reference *Mandatory*

Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken.

Well formulated terms of reference are essential to ensure that the

Essential

review is:

- Thoroughly scoped
- Manageable
- Conducted by the appropriate people
- Within agreed timeframes.
  - To establish facts of the case
  - To analyse and evaluate the evidence
  - To risk assess
  - Make recommend

Ensure the review will answer "**THE WHY**" question.

Interface with other review processes
Mandatory

See appendix 1

Before starting a SAR identify if there is any links to other reviews and identify which takes priority. For example:

- DHR
- Children's SCR
- Serious Further Offence Review (Probation)
- Mental Health Review

In addition - Consider previous SAR's – will a recent SAR reinforce the same learning or is new learning to be identified?

Family & significant others involvement
Mandatory

Identify the degree to which victims/families will be involved in the review and how they will be informed of this review.

Victims/families (family members who have played a significant role in the life of the service user) should be notified that the review is taking place. Involvement can be:-

- Formal notification only
- Inviting them to share their views in writing or through a meeting.

The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.

Victims/families should be offered support.

Independent Advocacy
Mandatory

The local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding adult review. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 then, unless inappropriate, the same advocate should be used.

It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process.

Chair
Mandatory

Each SAR will require a skilled and competent Chair of the panel considering the SAR, receiving Independent Management Reviews (IMR) and agreeing the report and recommendations. When identifying who to chair the panel – consider:

- Are they independent of the case?
- In single agency reviews – are they independent of the single agency that it involves?
- Do they need to be independent of the SAB?
- What skills, knowledge and expertise do they specifically need?

Panel
Mandatory

Each SAR should be presented to a panel for scrutiny.

The panel should be made up of a minimum of 3 people excluding the chair.

They must be:

- independent of the IMR authors
- Independent of the case
- Knowledgeable of the issues/subject area.

Practitioner involvement
Mandatory

Practitioners will be involved in all SAR's – however the level of their involvement can be varied.

The following should be considered:

- Interviewing and taking a statement from practitioners for IMR's can result is staff having heightened anxiety.
- Practitioners must be offered support throughout a SAR.
- Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome.

Multi agency learning events that involve practitioners can:

- Be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event.
- Assist practitioners to contextualize what happened and achieve closure.
- Result in quicker and more enhance learning.

Overview Report & Executive Summary
Mandatory

An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced.

An Executive Summary may also be commissioned.

All reviews of cases meeting the SAR criteria should result in a report which is published and readily available on the SABs website for a minimum of 12 months. Thereafter the report should be made available on request. Do we want to add a retention timescale.This is important to demonstrate openness, transparency and candour and to support national sharing of lessons. From the start of the SAR the fact that the report will be published should be taken into consideration. SAR reports should be written in such a way that publication will be likely to harm the welfare of any adult with care and support needs or children involved in the case. Exclusion to this rule would be single agency reviews if individuals can be identified.

Final SAR reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- The type of abuse or neglect being considered.
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

Independent Author
Optional

In the following situations it may be beneficial to consider an author who is NOT the chair:

- Very difficult and complex cases to enable the chair to concentrate in chairing
- Due to the specialist nature of the subject.
- To enable the chair to be from the SAB and be the chair as part of his day to day work.

An independent author must be:

- Independent of the case
- Independent of the organisations involves
- Appropriately skilled and competent.

They may also be independent of the SAB.

Experts
Optional

Consider if an expert is required to help to fully understand the situation and IMR findings.

If possible, identify which expert will be needed or may be needed at the start of the process. However, experts can be called upon at any time during the process.

Chronology
Optional

A chronology can provide a timeline – a sequence of events.

A clear chronology of events in a safeguarding case can show agencies where risks and can be used to cross reference significant events.

If using a chronology, consider:

- The timeframe
- What you mean by key/significant events
- Using an agreed terminology avoiding abbreviations – for example Nurse A in one organisations chronology may not be the same Nurse A in another organisation's chronology.

For complex cases it is recommended a chronolater tool is used.

13. References:

Care Act 2014

Department of Health (October 2014) Care and Support Statutory Guidance – issued under the Care Act 2014.

Social Care Institute for Excellence (2015) Safeguarding Adults Reviews under the Care Act – implementation support.

Warwickshire Safeguarding Adults Partnership – Safeguarding Adults Review (SAR) Protocol and Guidance

London Joint Improvement Programme: Learning from Serious Case Reviews on a Pan London Basis, Sue Bestjan, March 2012

Shropshire and Telford & Wrekin Safeguarding Adults Board – Multi-Agency Procedure for Safeguarding Adults Reviews

Solihull Safeguarding Adults Board Local practice Guidance – Safeguarding Adults Reviews.

Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children March 2013

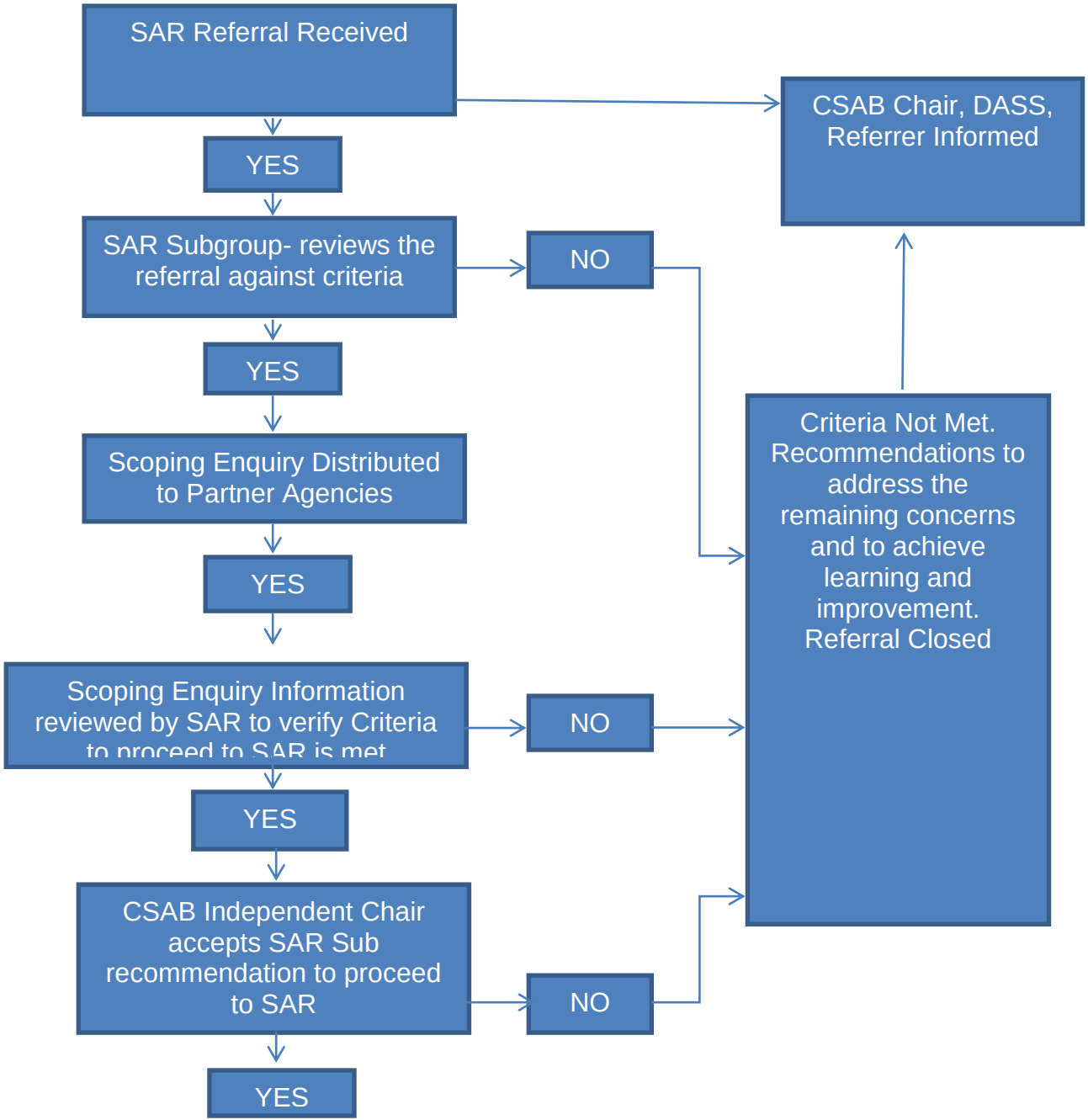
Appendix 1

Interface with other reviews

Review	Precedence
Domestic Homicide Reviews (DHR) Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	When the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that: the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by - (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Children's Safeguarding Practice Reviews (SPR's) Children's and Social Work Act 2017 section 17. For further guidance see – HM Government - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children 2013	**Local child safeguarding practice reviews** (1)The safeguarding partners for a local authority area in England must make arrangements in accordance with this section— (a)to identify serious child safeguarding cases which raise issues of importance in relation to the area, and (b)for those cases to be reviewed under the supervision of the safeguarding partners, where they consider it appropriate.
Serious Incident Investigation/ Root Cause Analysis within health organisations	It is accepted that this is already part of the national Serious Incident Reporting framework (SIRI) in health settings. Where necessary final reports of SIRI's will be reviewed by the board.

Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review Criminal Justice and Court Services Act 2000 - strengthened by the provisions of the Criminal Justice Act 2003 (s325−327).	When the main purpose is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.
Serious Further Offending Notification and Review Procedures Offender Rehabilitation Act 2014	Reviews will be required in any of the following cases:- - any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the National Probation Service (NPS) or a Community Rehabilitation Company (CRC); or whilst subject to Release on Temporary Licence (ROTL). In addition, this will also apply during the 28 day period following conclusion of the management of the case; or - any eligible offender who has been charged with another offence on the Serious Fraud Office (SFO) qualifying list committed during a period of management by the NPS or a CRC and is or has been assessed as high/very high risk of serious harm during the current sentence (NPS only) or has not received a formal assessment of risk during the current period of management; or - any eligible offender who has been charged with an offence, whether on the SFO list or another offence, committed during a period of community management by the NPS or a CRC, and the provider of probation services or National Offenders Management Service (NOMS) has identified there are public interest reasons for a review. This may be due to significant media coverage Ministerial interest or where reputational risks to the organisation may arise; or - if the offender has died and not been charged with an eligible offence but where the police state, he/she was the main suspect in relation to the commission of a SFO.

Appendix 2 – Stages of the SAR Process



Safeguarding Adult Review (SAR) Referral Form and Decision Record

WEST MIDLANDS REGIONAL ADULT SAFEGUARDING LEADS
DEVELOPING POLICIES AND PRACTICE ACROSS THE REGION

This form should be completed to make a SAR referral and forwarded to the relevant Safeguarding Adults Board

Which Board do you want to refer to?	Choose an item.

The responsible Safeguarding Adults Board will consider every referral on the basis of whether it meets the Safeguarding Adults Review criteria as stipulated in section 44 of the Care Act 2014 which states:

(1) A Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:
   a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguarding the adult

   And

   b) Either of the following conditions are met –

(2) Condition 1 is met if –
   a) The adult is still alive, **and**
   b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it know about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if –
   a) The adult is still alive, **and**
   b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

Further information about Safeguarding Adult Reviews can be found within the local Safeguarding Adults Board protocol and supporting documents.

A SAR will not blame any organisation or person for something that has not worked well. It is not an alternative to a complaint. The SAR process looks at whether any lessons can be learned about the way organisations worked together to support and protect the person who died or suffered harm.

How can I refer a case for review?

- Any **professional** can make a referral. If you know of a case that meets the SAR criteria, then you should first discuss a possible referral with the safeguarding lead for your organisation.
- A member of the public that wishes to make a referral should contact the worker involved with the person's care to discuss the circumstances. The worker will then assess whether there is sufficient evidence to make a referral on their behalf.
- Cases that have the potential for a SAR and notification of any single agency reviews should be referred immediately.
- Referrals should be quality assured and authorised by your agencies Safeguarding Lead or a Senior Manager prior to submission.
- All referrals must be submitted securely. Please contact the local SAB to discuss as required.
- Referrals will be considered for a review and the referrer informed of the outcome.

Section 1 – TO BE COMPLETED BY THE REFERRING AGENCY

Please complete all sections and include as much information as possible to ensure that the decision-making process is robust and proportionate.

This document contains sensitive personal data so please ensure your email is secure or encrypted.

1. Details of person making referral	
Name	
Position	
Agency	
Address	
Phone Number	
E-mail	

2. Details of the person being referred	
Name	

Date of birth	
Date of death (if applicable) Inquest date (if known)	
Address	
Care and support needs/significant medical information	

3. Details of the representative/family of the adult with care and support needs- it should be noted that contact with the family is not required at this point	
Does the adult have any family or representative as far as you are aware?	Yes No (if no move to question 4)
Are they aware of the SAR referral?	Yes No
Family member/representative contact name	
Relationship to the adult	
Phone number	
Address	
Is there any reason the family should not be contacted if a decision is made that the case	Yes No (if Yes please give details)

meets the criteria for a SAR?	

4. Notification of other reviews being undertaken

☐ Domestic Homicide Review (DHR)

☐ Multi Agency Public Protection Arrangements (MAPPA) review

☐ Root Cause Analysis (RCA)

☐ Child Safeguarding Practice Review

☐ Learning Disabilities Mortality LeDeR Review

☐ Other

Date review commenced:

Date review completed:

Please provide details including recommendations where known:

5. Please provide a brief summary of the case and the circumstances that led to the referral including any practice issues identified.
Please include details of: victim (age, gender, ethnicity), the care and support needs, living situation, location of the abuse/incident, type of abuse/safeguarding issue, and who the source of risk is.

6. Please outline the factors that suggest the SAR <u>criteria</u> are met: Please refer to the front page of this referral form and include in detail how you feel the circumstances meet the criteria for a Safeguarding Adults Review **<u>responding fully to each separate criteria.</u>** For the circumstances to meet the criteria there must be concerns about how separate agencies **<u>worked together.</u>**
a) The adult has care and support needs/significant medical information – Specify below:

b) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult. Specify below:
Supporting Information to include in what way agencies did not work together which led to the abuse.
c) The adult has died (suspected to be resulting from abuse or neglect). Specify below:
Supporting information to include what the abuse and neglect consisted of:
d) The adult is still alive and suspected to have experienced abuse or neglect:
Supporting information to include what the abuse and neglect has consisted of:

7. Please list the agencies/service providers known to be involved in this case. Please include the GP

8. Please provide any additional information you feel is relevant.

The Safeguarding Lead for your agency should sign below to confirm that they are in agreement for this referral to be made to the SAB.

9. Please account for any delay in the referral being submitted.

Signed:…….. Print name:……..

Senior Manager/Designated Safeguarding Lead/SAB Member

Date Authorised: ……
Reason for referral without authorisation (if applicable):

Section 2
TO BE COMPLETED ON BEHALF OF THE SAFEGUARDING ADULTS BOARD

2a Record of where a Request does not meet a SAR criteria and is being closed without scoping

Date	Decision made by	Decision/comments
Expands to fit	Expands to fit	Expands to fit

2b Record of Discussion/s at the Scoping Meeting

Attended by:	
Name	**Title & Organisation**

Date	Discussion (including consideration of the factors highlighted for consideration within the Quality Markers)	Decision

Expands to fit	Expands to fit	Expands to fit

Agencies who have not responded to the request for information and action taken:

After reviewing the information from all involved agencies it is recommended that this case:		
i	Meets the criteria for a SAR under S44 (1) and (2) or (3) of The Care Act 2014	
ii	Meets the criteria for a SAR under S44 (4) The Care Act 2014	
iii	Does not meet the criteria for a SAR under S44 The Care Act 2014	

Recommendation to SAB Chair

It is recommended/not recommended that this case is subject to a SAR for the following reasons (include rationale for recommendation and consideration of MSP, information on key areas of enquiry, methodology and timeframe):

If the case does not meet the criteria for a SAR and another review process has been agreed, please give details below (please refer to the guidelines):

Please account for any delay in decision making:

Signed: ……

Scoping Meeting Chair

Date: ……

SAB Chair Decision

Signed: ……

Date: ……

Appendix 4

SAR Scoping Letter

Coventry Safeguarding Adult Board

SAFEGUARDING ADULT REVIEW SCOPING PANEL INFORMATION REQUEST FORM

Name of person at risk:
DOB: **DOD:**
Last known address:
The following information is required to identify which agencies need to attend the Scoping Panel Meeting on: **Date / Time / Venue**
Please provide the following information:

Name of Agency Completing Return:

_____

Name and designation of the individual completing this form:

_____

Date completed:

	Question	Yes	No
1.	Is the above named person known to your agency?		
2.	Is the above named person currently or has received services from your agency or a service you commission?		
3.	Do historical records exist in your agency in relation to this person? *(If yes please provide approximate dates).*		
		Dates:	
4.	Is any other member of the above named person's family known to your agency?		

5. a	Where a family member, other than the named person is known to your agency please identify: The family members name / relationship to the person	Names / relationship & D.O.B:
b	Are they currently receiving services from your agency*? (If yes please provide brief details)*	 Details:
6.	Please note any further information that you think may be helpful. This could be for example; other significant family members or people involved in the life of the person; other addresses; dates of birth; or agencies.	Any other Information:

Please return this form in a secure manner by (Date) to: (Return e-mail address)
The CSAB will be able to notify agencies to confirm whether or not they are required to attend the Scoping Panel Meeting once all of these forms have been returned.
If you require any further support, please contact the Safeguarding Board support team on 024 7683 1477

Appendix 5

SAR subgroup Decision Record and Referral Recommendations

Name of Adult(s):	
Date of Birth:	
Date of Death:	
Referring Agent:	
Date Referral Received:	
Reason for Referral:	

Agencies providing information	Summary of Details

Other learning opportunities considered:	**Comments:**

Date referral considered by SAR subgroup:	
Recommendations and the rationale:	
Signature of SAR subgroup Chair/Deputy	
Independent CSAB Chair:- **Decision:** **Date:** **Time** **Signature:**	

Appendix 5a/5b

SAR Independent Chair and Author Contract Template


Author


Chair

Appendix 6
Coventry SAR Chronology Template

Agency Chronology	
Name of Agency:	
Name of Adult(s):	
Date of Birth:	
NHS Number	
Date of Death (if known):	
The information required under each heading should be fairly self explanatory. **IT IS VERY IMPORTANT THAT YOU INSERT THE DATE AS PER THE EXAMPLE.** **When detailing the time of the contact please use a 24hr clock.**	

Date of contact: *dd/mm/yy*	***Time of contact:*** *24hrs clock please*	***Source of Evidence*** *e.g. Case File*	***Contact with Whom*** *e.g. Name, Service user*	***Method of Contact*** *e.g. letter, T/C, Email, Face to Face, Fax*	***Details of contact/event***	***Actions taken/decisions made***	***Does the record demonstrate that expected practice requirements were met?***	***Was GOOD practice identified (e.g. it was over and above what would be usually expected)***	***Flag if ther are any gap that mean y are unable determine expected practice wa delivered.***
Example 1 01/04/2019	*10:20*	*Letter*	*L. Pink, Daughter*	*T/C*	*Invite to Strategy Meeting on 5/04/2019*	*Cannot attend asked for report on recent involvement since 01/03/2019*	*Yes*		
Example 2 06/09/2019	*14:15*	*Nursing Records*	*Adult (subject)*	*Face to Face*	*re progress and what happens next*	*No action recoded*	*No*	*No*	*A record was made to conf what informa was provided*

Date of contact: *dd/mm/yy*	***Time of contact:*** *24hrs clock please*	***Source of Evidence*** *e.g. Case File*	***Contact with Whom*** *e.g. Name, Service user*	***Method of Contact*** *e.g. letter, T/C, Email, Face to Face, Fax*	***Details of contact/event***	***Actions taken/decisions made***	***Does the record demonstrate that expected practice requirements were met?***	***Was GOOD practice identified*** *(e.g. it was over and above what would be usually expected)*	***Flag if ther are any gap that mean y are unable determine expected practice wa delivered.***

The information which is required under each heading should be fairly self-explanatory. The last column "comment" should be used if the agency reviewer wishes to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue.

It is important that you insert the date as per the examples to facilitate merging with chronologies from other agencies and that nothing else is entered in the date column.

Please submit your Chronology to the Administrator Lillian.symonds@coventry..gov.uk.

Please submit your completed IMR to the Administrator Lillian.symonds@coventry.gov.uk

Appendix 7
Coventry SAR Independent Learning Report Template

SAR Independent Learning Report

STRICTLY CONFIDENTIAL

Independent Learning Report from: *Insert Agency Name*
SAR: *Insert agreed initials/reference*
Author: *Insert name and the designation of the author. Provide a brief summary of why your role equips you to undertake this review and verify that you have had no operational involvement in this case, therefore, can undertake the review from an independent stand point.* **Signed:** **Date:**
Countersigned: *Insert name and designation this signatory should be a senior manager who has the authority to sign off the report on behalf of the agency* **Signed:** **Date:**

Version:	
Ratified by:	
Ratification Date:	
Document Sponsor:	
Document Author	
Issue Date:	
Review Date:	

(state final version only when the report is so)

Contents: **Page**

Your report must remain fully anonymised throughout. This applies to names, addresses, identifiable locations and professional names.

i) Introduction

This Independent Learning Report has been developed by *insert name of organisation* in accordance with the CSAB procedure for undertaking a SAR. The purpose of the review process is to enable agencies to identify those learning opportunities which can improve practice and services across Coventry.

The review will look critically and openly at those things that may have caused harm and with the benefit of hindsight consider whether there were practice gaps in the way that single agencies or multi agencies worked at that time which need to change to ensure the safety of those adults at risk.

About the Organisation

Provide a brief summary of the organisation, the services it offers and what was the involvement the organisation had in relation to the key individual sin this case

Terms of Reference

The terms of reference applied to this case review have been agreed as follows:
Insert a copy of the terms of reference.

Methodology

This review has been informed by the following sources of information:
Insert the information sources your agency has reviewed which may include agency policies and procedures, management information, training records, case notes, supervision records, interviews held with key staff involved in the case or where this was not possible making reference to this and why it was not possible to do so. If any additional reviews had been carried out by the agency, verify the current status of this and include any findings which might be relevant to this SAR.

ii) The Family

Include a pen picture of the adult at risk, the alleged responsible person(s) and other key family members. You can include a genogram to represent this as this may add value to the overall report. Please use the agreed initials or reference digits and include the relationships to each individual.
Identify those staff who had contact with the family and provide a brief summary of your agency's involvement with them.

iii) The chronology of events and service provided

A comprehensive chronology which maps the involvement the agencies have had with the adult at risk, significant others and those person(s) alleged to be responsible will have been produced. It will cover the period set out in the terms of reference and provide a summary of events at that time including all the relevant information held by the agency such as assessments, how decisions were reached, actions taken and services provided.

This section provides an accompanying narrative and will highlight the significant episodes of involvement provided by your agency and provide details of the reason for the involvement.

iv) Analysis of Events

The analysis will study the events that occurred and reflect on the decision that were or were not made and why this was the case. Actual practice will be examined against current policies, guidance and legislation.

Examples of what need to be included in the process of analysis:

- *Practitioner standards and services provided. This section will consider was service delivery in line with the organisation's expectation and comparable with national standards for similar services. Did the practitioners engage sensitively with the adult at risk, and were they knowledgeable about their potential risk factors? Did they know how to escalate any concerns? Was a suitable level of supervision provided for the practitioner and had they received sufficient training to support them to deliver appropriate care and services? What was the involvement of senior management in the case? It is also important to highlight those areas of good practice and those events that went well.*
- *Policies, procedures and assessment of risk. Were the policies and procedures fit for purpose and did the practitioner apply them and if not why not? Did the policies include risk assessment and were these followed by the practitioners involved in the case? Provide details of what assessments did take place and how these influenced the decision making. Include what thresholds were applied to the assessment process*

and how these were reflected in the service provided. Were plans reflective of relevant time frames i.e. reviews, further assessment and visits?

- *Person – centred approach. Was there evidenced that the wishes of the individual was at the centre of the decision making and that all reasonable options were considered in this process? Did practice demonstrate the sensitivity of age, gender, physical and mental capability, ethnicity, language etc. Were any of these factors considered and if so responded to appropriately?*
- *Partnership working. Did all the partner agencies work in accordance with their shared policies, and was their evidence that they worked positively together to share information and local intelligence to improve services for this adult at risk? Were there good examples of partnership working?*
- *Good practice. Were there areas of good practice which could be shared with a wider community? Provide examples of good interagency practice and where practice had adverse consequences.*
- *Lessons to be learnt. What lessons are there to be learnt from this case which can be used to improve practice and services in the longer term. What are the implications of any service or practice change for staff training, supervision and working in partnership? some detail of why practices and services did not meet the required expectations and what things might need to change in relation to organisational structure, culture or political stand point. Did events have a negative impact on service activity and what can be learnt from this? Are there similar learning themes identified in this case which were also a feature of previous SAR's, this needs to reflected in the learning.*
- *Terms of reference. Also include any specific points within the terms of reference not covered in the sections above.*

v) Conclusions

The conclusion will draw together the findings and analysis and provide a detailed commentary which summarises these aspects of the review. It will include:

- *Reflection of services provided, and the quality of practice in the context of policy requirement.*
- *Policy suitability , was it fit for purpose*
- *Action and decision making*
- *Any resource implications affecting the outcome for the adult at risk.*

vi) Recommendations

Each agency will make recommendations and action that needs to be considered by the review panel within their report for inclusion within the overview report. The review panel can also add additional recommendations for inclusion in the overview report.

Each agency is responsible for acting on any recommendations not included in the report in accordance with their respective governance arrangements.

The recommendations must reflect the conclusions made from the review and any recommendations which require immediate action must be raised with the relevant agency senior manager and the SAR subgroup and should not be delayed until the review report is finalised.

vii) Feedback

Identify how your organisation is planning to feedback the lessons learnt from the SAR process internally to staff involved and to a wider practitioner audience.

viii) Checklist for Learning Report Authors

1.	The learning report author is independent of case under review and this is clear within the report?	
2.	The author has included a summary of the role of the organisation?	
3.	The author has provided a brief overview of their background and experience relevant to the learning report authorship role?	
4.	The author has completed the template provided in the toolkit and has kept the identity of all individuals referenced in the report anonymised. Professionals are identified by job title and listed on a separate appendix to the report?	
5.	The Terms of Reference are set out in the text and each term of reference has been answered as appropriate by the agency?	
6.	The learning report verifies which reports/records/policies have been accessed?	
7.	All the relevant staff have been interviewed and if this was not possible the reason included in the text?	
8.	The report remained person focused throughout capturing the voice of Adult at risk and others involved?	
9.	Issues of race, culture, language, religion etc., have been addressed within the report?	
10.	The learning report presents a balanced and structured document which analyses the practices and services candidly including what was good?	
11.	The conclusions reached within the learning report are well balanced and identify the key lesson to be learnt?	
12.	The lessons learnt have driven the recommendations which are SMART and able to effect positive, sustainable change and improvement	
13.	The learning report has been signed off by a senior manager who has the authority within the organisation to do this?	
14.	Managing staff feedback is clearly stated within the report?	

NHS
Coventry and Rugby
Clinical Commissioning Group

Gaining consent - Serious Case Review, Serious Adult Review or a Domestic Homicide Review.

National legislation requires regional safeguarding boards to undertake case reviews in certain circumstances. These reviews are aimed at ensuring that lessons are learnt to help services improve for patients in the future. These reviews are achieved by accessing the medical notes of children, adults or their families. The professionals involved in these cases will often be interviewed as part of this process for additional information that is not in the medical notes. The law says that reviews of this nature will nearly always be published online in a highly anonymous style. Patients may recognise their story if they read the publication but they will not be named.

General Medical Council (GMC) guidance says GPs should fully participate in these reviews, it details that consent is not always needed as GPs can justify release "in the greater public good" or even if consent is refused. However, it is best practice to have patient consent or for them to know information has been released even if it is without their permission. Very occasionally the professionals around a patient may justify not informing the patient if it is likely to cause further distress or increased risk by attempting to gain consent. The Medical Defense Organisation's can help professionals with these issues if you need help or support with interpretation of the GMC guidance.

GMC Guidance link: http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_56_63_child_protection.asp

GP practices will sometimes be provided with a signed consent form by the safeguarding board that may have established contact with the family. Alternatively the GP practice themselves may be asked to gain consent to release the medical records.

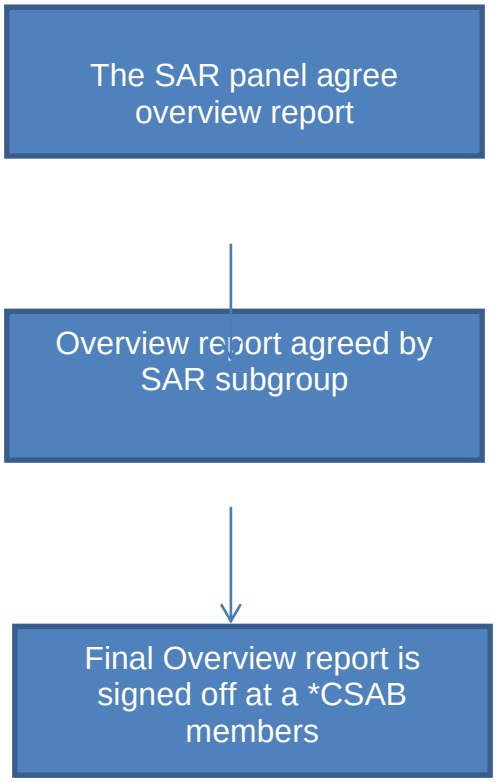
If you are asked to contact the family to gain consent please use this document as a guide to explain that the process is highly confidential, designed to improve care for other patients in the future, required by law and always anonymous in any publication.

Please contact the safeguarding team if you have further questions.

Tel: 024 76246019
Email: CRCCG.Safeguarding@nhs.net

Appendix 9

Approval process for Safeguarding Adult Review



*report to be sent a week in advance of meeting