

**Safeguarding Adults Review Policy and Procedure**

**April 2025**

**Document information**

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| North Yorkshire Safeguarding Adults Board (NYSAB) | Adrian Green  Independent Chair of NYSAB |
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**Safeguarding Adults Review Policy**

# Introduction

* 1. The Care Act 2014 provides a statutory basis for learning and review processes. Safeguarding Adults Reviews (SARs) provide an opportunity to learn lessons when abuse or neglect is suspected to be a factor in the death or serious harm of an adult with care and support needs.
  2. It is the responsibility of all partner agencies to make a referral for a SAR where there are reasonable grounds to consider the criteria for a SAR are likely to have been met.
  3. All partner agencies have a responsibility to ensure that staff know the criteria for a SAR, their purpose and function. All partner agency staff must know how to refer a case for consideration via the NYSAB Business Unit.
  4. The SAR related meeting structure can be seen below:
  5. The quarterly SAR Subgroup maintains oversight of and monitors progress of all SARs. Underneath this, SAR referrals are received into individual monthly SAR Scoping Panels. These will consider whether the referral meets the criteria to conduct a SAR, a decision which is ultimately ratified by the NYSAB Independent Chair.
  6. A SAR Scoping Panel must include an appropriate senior representative from the following agencies:
     1. North Yorkshire Council (NYC) Health and Adult Services (HAS)
     2. North Yorkshire Police
     3. Humber and North Yorkshire Health and Care Partnership (ICB)
  7. A SAR Scoping Panel will be considered quorate with representation from the three statutory agencies (North Yorkshire Police, Local Authority and Integrated Care Board), who are required to be of appropriate seniority and experience.
  8. Other relevant representatives that have had involvement with the case will be invited as required, to assist with decision making around S44 criteria.
  9. The NYSAB, via its Independent Chair, is the only body in North Yorkshire that commissions SARs.
  10. Commissioned SARS will be actioned via SAR Delivery Groups, with progress fed back into the SAR Subgroup.
  11. The policy and practice undertaken by the NYSAB strives to reflect the SAR Quality Markers published by the Social Care Institute for Excellence (SCIE). A copy of the markers can be found here: <https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers>

# Purpose

* 1. The SAR is a learning-focused process as required by the Care Act 2014, designed to have practical value by illuminating barriers and enablers to good practice, exploring systemic risks, and progressing improvement activities.
  2. The purpose of a SAR is to determine where multi-agency working went well and what might have been done differently that could contribute towards preventing similar harm or death reoccurring in the future. It therefore requires outcomes that:
     1. Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies were involved in the care and support of an adult at risk of abuse and/or neglect.
     2. Review the effectiveness of safeguarding systems, procedures and practice both of individual organisations and multi-agency arrangements.
     3. Inform and improve future practice by acting on the findings (developing best practice across all organisations).
     4. Highlight any good systems, procedures, practice or opportunities to improve, identified within the review.
     5. Lead to recommendations to be implemented.
  3. The purpose of the review is not to identify or apportion blame or hold any individual or organisation to account as other processes exist for this, including coronial procedures, criminal proceedings, disciplinary procedures, employment law and professional regulation.

# 3. Criteria for a SAR

* 1. The criteria for a SAR is when:

1. an adult in the NYSAB area has care and support needs (whether or not the local authority was meeting any of those needs);

and

b1. either dies, and the NYSAB 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)

**Or**

b2. NYSAB knows or suspects that the adult has experienced serious abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died or serious or significant harm occurred).

**and in both cases**

1. there is reasonable cause for concern about how the NYSAB, members of it (or other persons with relevant functions) worked together to safeguard the adult.
2. or the Safeguarding Adults Board believes that there is learning to be identified/embedded for future use/reference.
   1. Where the mandatory SAR criteria is met a SAR must be commissioned. A SAR will be led by an author who will be responsible for undertaking the review, developing the recommendations and writing the report. In most cases, this will be an independent author commissioned to undertake the SAR on behalf of the NYSAB. The Independent Chair will then consider how this is done and whether a full review needs to be undertaken if the learning has already been identified but not yet actioned. e.g. learning has been taken from a similar SAR, or consideration of thematic reviews.
   2. Where referrals relate to individuals who have died or been seriously injured within North Yorkshire area, but it is more appropriate for another area to conduct a review or another SAB, this will be considered by the independent Chair who will discuss the matter with the appropriate board Chair. The default position in the absence of agreement will be that the SAB where the death or injury occurred will be the commissioning board.
   3. The NYSAB may also undertake a SAR in situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice. This will be actioned at the discretion of the SAR Scoping Panel and with agreement by the NYSAB chair.

3.3 Following a significant event, active consideration should be made as to whether or not a referral for a SAR is required. To support this, organisations should consider including an appropriate trigger question on internal incident reporting, investigation and/or review templates, or have appropriate mechanisms in place to be able to readily identify scenarios that require referring into the SAR process.

3.4 It is important to note that the SAR notification process does not affect any internal review processes.

3.5 Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with care and support needs. If the SAB requests relevant information from an organisation or person, then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB.

3.6 In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered serious or significant harm as a result of the abuse or neglect.

# Making a SAR referral

* 1. Any agency representative, local councillors, Members of Parliament or professional **MUST** refer a case believed to meet the threshold of the criteria identified above (see 3.1 a., b. and c.)in a timely manner, by completing the SAR Referral Form and Decision Record (Appendix 1) and submitting it to the NYSAB Business Unit via email address: [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk), or post: NYSAB, North Yorkshire Council, County Hall, Racecourse Lane, Northallerton, England, DL7 8AD
  2. A case may also be referred by other interested parties including the family as above.
  3. The SAR Scoping Panel may choose to invite those making a referral in their professional role to present the case to the panel. This is to enhance the opportunity to understand fully the context of the case prior to a decision being made.

# Making decisions on SAR Referral

* 1. Within 5 working days, on receipt of a referral, the NYSAB Business Unit will:
  + acknowledge the notification,
  + quality check the referral, and seek further information if required
  + advise the SAR Subgroup Chair and NYSAB Independent Chair of the referral.
  1. Where the SAR referral does not indicate the statutory criteria are met, the NYSAB Business Unit may ask the referrer to provide further information. If upon receipt of further information it is clear the referral will not meet the s.44 criteria, the referral will not be progressed. The referrer will be notified of the outcome by a member of the Business Unit and recorded using part 2 of the SAR Referral Form and Decision Record (Appendix 1).
  2. Once the referral is accepted, a Safeguarding Adult Review – Initial Request for Information (Appendix 2) will be issued to each partner agency by the NYSAB Business Unit. This includes any services that have had involvement with the person. The purpose of this is to collect relevant information that adequately informs the discussion on whether the SAR criteria are met.
  3. Accepted SAR referrals will be considered at the next monthly SAR Scoping Panel meeting, providing this is quorate. If not, then an extraordinary meeting will be arranged.
  4. In deciding whether a SAR should be recommended, the SAR Scoping Panel must first consider whether the s.44 criteria for a SAR is met using the criteria outlined in paragraph 3.1 above.
  5. Appropriate scrutiny should be given in relation to the Safeguarding Adult Review – Initial Request for Information when determining whether the statutory criteria are met.
  6. When considering a SAR referral, the SAR Scoping Panel will need to establish if there is learning from a multi-agency or single-agency perspective. It is important that consideration be given to the increasingly complex landscape of the commissioning and provision of services.
  7. Each member will need to provide a verbal/written rationale for their decision as to whether the SAR criteria is met. The NYSAB Business Unit are not part of the decision-making process.
  8. The SAR Scoping Panel’s recommendation as to whether the SAR criteria is met will be forwarded to the NYSAB Independent Chair who will make the decision as to whether to undertake SAR, and if so how it should be completed. The referrer will be notified of the outcome by a member of the Business Unit and recorded using part 2 of the SAR Referral Form and Decision Record (Appendix 1).
  9. If a recommendation cannot be reached by consensus, a majority decision will be shared with the NYSAB Independent Chair who will decide whether the criteria is met and whether to undertake a SAR.
  10. The SAR Scoping Panel may consider that although the mandatory s.44 criteria is not met, there will be benefit in conducting a SAR to promote effective learning and improvement action in order to prevent deaths or serious harm occurring in the future, under s.44(4) of the Care Act 2014. These reviews can provide useful insights into the way organisations are working together to prevent and reduce the abuse and neglect of adults in North Yorkshire.
  11. The SAR Scoping Panel can recommend the following where the mandatory or discretionary criteria for a SAR are NOT met:
* No further action
* Commission a SAR

The SAR Scoping Panel will also consider and identify what single agency reviews may provide learning. This might involve separately, more than one agency. The group should state whether the agencies identified have agreed to undertake a single agency review.

* 1. It will be important to advise the SAR Scoping Panel of any governance issues and/or if other parallel proceedings are involved, for example, police investigations or Patient Safety Incident Response Framework. If a person has died, the NYSAB Business Unit may contact the Coroner to identify whether an inquest has or will be held.
  2. The SAR Scoping Panel will also consider whether another review or learning process has already commenced which NYSAB could potentially feed into, e.g., Domestic Homicide Review [DHR], Learning Disabilities Mortality Review [LeDeR]., however if mandatory criteria are met the NYSAB must carry out a SAR.
  3. SAR process will not as a matter of course share material gathered as part of the SAR with another agency or parallel proceedings without the consent of the NYSAB Independent Chair.
  4. Should the referrer challenge the decision of the SAR Scoping Panel the Independent Chair of the NYSAB will respond. The decision can be re-visited if new information has come to light. Any challenge to the decision should be made to the Independent Chair of the NYSAB via the Business Unit e-mail within 28 days of the feedback being received.
  5. The Business Unit will support the SAR Subgroup to keep a record of all cases that have been referred and considered for a SAR.

# Undertaking a SAR

* 1. Where the s.44 criteria is met, the NYSAB Independent Chair is responsible for deciding whether a review is undertaken or not, and agreeing the rationale for this. For instance, in some cases learning may already have been gathered through an alternative learning process and another review would only duplicate this learning.
  2. Once the decision has been made to instigate a SAR, the Business Unit on behalf of the NYSAB Independent Chair will write to the nominated lead of each organisation concerned advising advise them that a SAR has been commissioned and requesting them to nominate an appropriate senior member of staff to support the review process (see Appendix 4). Contact will be made with the Senior Investigating Officer from the relevant police force if criminal investigation is underway, to ensure any review does not undermine police investigations. The SAR may include information already gathered through other investigations (e.g., Safeguarding Enquiries or Adult Social Care Serious Incident Reviews).
  3. The SAR Scoping Panel will identify and convene (via the Business Unit) an appropriate SAR Delivery Group to meet at the earliest opportunity. The SAR Delivery Group will comprise of relevant senior representatives from the key organisations involved in the case – this will usually follow the same membership as the SAR Scoping Panel. A Chair will also be appointed to lead the SAR Delivery Group.
  4. The relevant SAR Delivery Group will be responsible for progressing the SAR process from commission through to action planning.
  5. The methodology selected by the SAR Delivery Group must offer the most effective learning and involvement of key staff/family weighed against the cost, resources and length of time required to conduct the review.
  6. The SAR Delivery Group will create the Terms of Reference which will outline the most proportionate and appropriate methodology and avoid the potential for duplication of learning elsewhere. They will reference the six safeguarding principles set out in the Care Act and NYSAB’s Multi-Agency Safeguarding Policy and Procedures and specify the time parameters of the SAR. The Terms of Reference should require an appropriate pseudonym unless otherwise agreed by the Chair. The SAR Sub-group and SAB chair reserve the right to not use the real name of a person if they feel it could prevent future trauma or risk.
  7. An Independent Author (IA) with the requisite knowledge, skills, experience and availability will be identified to undertake the SAR. Where an IA is commissioned, formal procurement processes for appointing an independent reviewer will be followed. The selection of an IA will include a declaration that the IA does not hold any conflicts of interest in accepting this appointment. If any arise during the process of the review the IA must declare this at the earliest opportunity to the SAR panel.
  8. The IA will be given access to related sensitive information via a secure platform, e.g. Egress mail, NYDrive, SharePoint or another closed secure network.
  9. The SAR Delivery Group and the Independent Author once identified, should consider and record who will and will not be consulted as part of the review and the rational for doing so.
  10. Where the subject of the review is alive, the SAR Delivery Group will give consideration to a communication plan within in the Terms of Reference. This will outline who is responsible for liaising with the person and/or their representative, and which relevant legal requirements will need to be followed. See Appendix 5 for further details about consent.
  11. Where there is agreed involvement of the person and/or their family, then in discussion with them, the SAR Delivery Group and the author, will agree how they and the interested party will be involved during the preparation of the report and in the final written report.
  12. The SAR Delivery Group will nominate and agree an individual within the SAB partnership to communicate with the family whilst the SAR is being undertaken. See Appendix 5 for further guidance. Where the person and/or their family do not wish to be involved in the development of the report this will be respected. However. they will still be offered an opportunity to review the draft report via a method as agreed with them with support if required.
  13. Via the NYSAB Business Unit, the NYSAB Independent Chair will write to the family or significant others in cases where the subject is no longer alive to inform them of the SAR, explain the process and purpose, and inform them of their point of contact. This should be completed as soon as practically possible. Reasonable and appropriate support and adjustments should be made by NYSAB as required to enable the adult(s), their family and/or representatives to participate in the SAR.
  14. Once the IA has been contracted, the timescales for completing the SAR will commence. Every effort will be made to complete the review within six months from which the IA is appointed. Where this will be not be possible, the matter will be discussed at the SAR Subgroup meeting and with the NYSAB Independent Chair. Updates will be recorded in the minutes of the SAR Delivery Group and SAR Subgroup meetings. Interested parties, such as the family will be notified as felt appropriate.
  15. The SAR Delivery Group will at key times as agreed during the SAR process to monitor progress and discuss whether any amendments to the Terms of Reference are required.
  16. Nominated agency representatives are required under the Care Act 2014 to supply all information that may be relevant to the SAR within the identified time parameters. They must ensure that they coordinate with other relevant members of their organisation to obtain the fullest understanding of their interactions.
  17. Nominated agency representatives also have a responsibility to explain the SAR process to others in their organisation and provide reassurance and support to their colleagues throughout the process. This support should be clearly identified and communicated to all staff involved. The death or serious injury of an adult at risk will have an impact on staff and may be felt beyond the individual staff involved to the team, organisation or workplace.
  18. The SAR Subgroup will receive and agree the draft report before it is presented to NYSAB, so that individuals are satisfied that the panel’s analysis and recommendations have been fully and fairly represented.
  19. The adult(s), if alive, to which the SAR relates and if appropriate, their family or representatives should also be given the opportunity to see the SAR report and recommendations. Ordinarily, two weeks will be afforded to read the SAR and provide any response. However, extensions will be granted at the discretion of the SAR Subgroup Chair if deemed appropriate to do so.

# 7. Making a decision on SAR methodology

* 1. Once it has been agreed to commission a SAR, the SAR Delivery Group will decide on the most appropriate and proportionate methodology to use. See Appendix 4 for further guidance. The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:
* **SAR Delivery Group** – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review, but should comprise a minimum of three members in addition to an appropriate chair, independent from who made the referral, and any other relevant agencies.
* **SAR Delivery Group Chair** – independent from who made the referral, and with appropriate skills, knowledge and experience (see below)
* **Terms of Reference** – compiled by the SAR Delivery Group and published as part of the review. These may be amended in consultation with the contracted author.
* **Early discussions with the adult if alive and if appropriate, their family, carers and representative** – to agree on if and if so, how they will be involved and how frequently they will be updated. Where appropriate, advocacy can be offered. See Appendix 5
* **Appropriate involvement of professionals and organisations who were working with the adult** – to contribute their perspectives without fear of being blamed for actions they took in good faith
* **SAR report and recommendations**

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

* Is the case complex, involving multiple abuse types and/or victims?
* Is significant public interest in the review anticipated?
* Is large-scale staff/family involvement wanted/appropriate?
* Are any criminal proceedings ongoing?
* Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
* What methodology is the most effective way to achieve the learning in the quickest timescales?
* Is a more appreciative approach required to review good practice?

# Outcomes from SARs

* 1. The SAR report should:
     + - Highlight key episodes, providing insight into good practice and opportunities to improve practice, systemic risks and multi-agency working to enable recommendations that will recognise best practise
       - Identify need for change to prevent similar incident re-occurrence.
       - It should be written with a view to being published.
       - Details of the person are included as judged necessary to illuminate the learning having been considered in line with the wishes of the individual or their family.
  2. The SAR delivery group has a responsibility to ensure there has been sufficient analysis, scrutiny and evaluation of evidence throughout the process. Recommendations must be of practical value, evidencing the wider outcome focused learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date.
  3. The NYSAB Business Unit will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process, to be held securely and confidentially for an appropriate period in line with NYSAB’s information sharing agreement, the General Data Protection Regulation (GDPR) and any other legal requirements.
  4. When the review has been completed and signed off by the Board, the SAR Subgroup will consider if, how and when the review will be published, taking into account any sensitivities and parallel proceedings. The SAR Subgroup will make a recommendation to the NYSAB Chair.

# Implementation of Action from SARs

* 1. The NYSAB is responsible for ensuring any learning identified within the report has clear recommendations to action change. The SAR Delivery Group will deliver on the recommendations via an Action Plan which must be SMART (Specific, Measurable, Achievable, Relevant and Time bound).
  2. The SAR Delivery Group is responsible for identifying an owner for each action and monitoring the actions on the composite action plan. It is the responsibility of NYSAB members to ensure that learning and service change from any safeguarding review is understood, embedded and evidenced with their organisation. NYSAB members will be held accountable for these actions at board meetings and via the SAR Delivery Group and SAR Subgroup.
  3. An action plan will be held by the SAR Delivery Group who will meet a minimum of four times a year to review and check progress on each action. Quarterly feedback will be fed into the SAR Subgroup.
  4. When all actions are completed, the SAR Subgroup will recommend the action plan for closure to the NYSAB Exec.
  5. Further assurance will be sought by the SAR Subgroup 12 months thereafter to ensure changes in practice have been embedded.
  6. Regular reports on the overall work of SAR Subgroup including ‘live’ referrals, action plans, including any themes and reviews will be presented to the NYSAB by the SAR Subgroup Chair.

# Communication of outcomes of SARs

* 1. The appropriate publication should be timely and publicise the key systemic risks identified through the SAR. Publication of the SAR will ordinarily be managed through the NYSAB website but adapted as necessary for the needs of different audiences. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and others. A pseudonymised report will usually be published unless the NYSAB Independent Chair agrees there are exceptional circumstances not to do so. In such an event, consideration will be given to what alternative approaches can be taken to publicise the outcomes, recommendations and learning gained by the review.
  2. As North Yorkshire Heath and Adult Services are the lead agency for adult safeguarding, media and communication activity about the SAR will be co-ordinated by the North Yorkshire Council’s Communications Unit on behalf of the Board and communication teams for other agencies involved in the SAR will be consulted as appropriate. North Yorkshire Council’s Communications Unit will be briefed as soon as a decision has been made to undertake a SAR and will be kept up to date with the progress of the review by the SAR Subgroup Chair or nominated officer.
  3. The NYSAB must include the findings from any SAR in its annual report and include what actions it has taken, or intends to take, in relation to those findings. Where the NYSAB is unable to implement a recommendation then it must state the reason for that decision in the annual report. The NYSAB maintains a public record, actions and commentary to enable public accountability.
  4. It will be NYSAB’s intention that SAR publications will be submitted for inclusion in the national SAR library.
  5. Where the recommendations for a SAR are linked to national issues and government policy, these will be escalated to the National SAB Chairs Network via the NYSAB Independent Chair. Any actions accepted by the national group will be updated as such on the SAR action tracker and closed pending an update.
  6. It should be noted that SARs sit outside of any NYSAB partner retention policy.

# 11. Dispute Resolution during SAR Process

11.1 It is recognised that disputes may arise at any stage during the SAR process, including whether a SAR should be commissioned, how it is commissioned and any aspect of the outcome of the review, including the content of the report. A dispute may arise because of a disagreement or complaint from anyone involved in the SAR process.

* 1. The NYSAB retains ultimate responsibility for the SAR process. Where a dispute arises, it shall be dealt with as follows:
  2. Those responsible for the relevant part of the SAR process shall attempt to resolve the dispute, for example, the SAR Delivery Group and/or the IA during the carrying out of a review. Any concern that cannot be resolved with be escalated to the NYSAB Independent Chair for a final decision.
  3. For disputes relating to the report content, the objecting party will provide written representation setting out their concerns to the SAR Delivery Group within five working days of being advised that the final draft report will not be amended.
  4. Where the NYSAB Independent Chair is unable to resolve the dispute, they may recommend that a reference to the dispute, and why it was not possible to resolve, should be included as an addendum to the report.

# 12. Safeguarding Adults Review Procedure

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|  | **Stage of Procedure** | **Role** | **Responsibility** | **Maximum Timeframe** |
| **1** | **Notification** | 1.1 Notifications for consideration of a Safeguarding Adults Review should be made to the NYSAB Business Unit using the SAR Referral Form and Decision Record form at Appendix 1  Upon receipt of a notification, the NYSAB Governance Team will:  a) Confirm receipt of the Referral Form  b) Screen the information received against the NYSAB SAR Policy and SAR Decision Support Guidance; and inform the NYSAB Chair.  c) Inform the referrer if the criteria are not met. Any referrals not progressed will be added to the agenda of the next SAR subgroup for transparency. | Referrer  NYSAB Business Unit | Within 5 days of the referral. |
|  |  | * 1. The **adult** and/or their representative will only be informed at this stage of the process if there *are exceptional circumstances.* The NYSAB Chair will have the final decision on what can be considered exceptional | NYSAB Business Unit on behalf of the NYSAB Chair |  |
|  |  | * 1. All partner agencies will be sent a copy of the completed Referral Form and asked to complete the SAR Initial Information Request form (Appendix 2). The forms are returned to the NYSAB e-mail account | All partner agencies | As soon as practically possible |
|  |  | * 1. If there are significant delays in receiving SAR Initial Information Request forms, the NYSAB Business Unit will escalate to the NYSAB Independent Chair. | NYSAB Business Unit |  |
|  |  | * 1. Health and Adult Services, North Yorkshire Police, and ICB should be represented at the SAR Scoping Panel Meeting in addition to the referring agency, and any other relevant professionals. | SAR Scoping Panel | As soon as practically possible once all chronologies are returned |
| **2.** | **Decision Making** | * 1. Compiled SAR Initial Information Request forms will be sent to SAR Scoping Panel attendees at least one week in advance | NYSAB Business Unit |  |
|  |  | * 1. All appropriate agencies should be invited to attend the SAR Scoping Panel including the referrer (using the information outlined on the Referral Form). | NYSAB Business Unit |  |
|  |  | * 1. The information contained in the Compiled SAR Initial Information Request forms should be considered by the group and a decision made using the NYSAB SAR Policy and NYSAB SAR Decision Support Guidance (Appendix 3) as to whether:  1. Whether more information is required 2. The mandatory criteria for a SAR are met or 3. The mandatory criteria are not met but a SAR would still be appropriate 4. The criteria are not met, and no further action is to be taken | NYSAB Business Unit  SAR Scoping Panel Chair/Group attendees | As soon as practically possible once all timelines are returned |
|  |  | * 1. The SAR Scoping Panel should also take into account:  1. Whether any other Statutory Review or significant processes are taking place (Children’s SPR, police investigation etc.) 2. What potential impact a SAR may have upon such investigations or proceedings 3. If there is a delay in the commencement of a SAR, then the SAR Subgroup Chair will ensure that any learning at this stage of the process is identified and shared with relevant parties. 4. the delay of the commencement of a SAR should not delay the implementation of any learning to improve outcomes identified by single agencies | SAR Scoping Panel Chair/attendees | As soon as practically possible once all chronologies are returned |
|  |  | * 1. The NYSAB Independent Chair will be informed of the decision in writing using the part 2 of the SAR Referral and Decision Making document – Appendix 1 | NYSAB Business Unit | Within two working days of the SAR Subgroup Meeting |
|  |  | * 1. The referring agency/person to be informed of the decision. Partner agencies to be informed via Appendix 4. | NYSAB Business Unit | Within ten working days of the NYSAB Independent Chair’s ratification |
|  |  | * 1. Any challenge to the decision should be made in writing to the NYSAB Business Unit or Chair of the SAR Scoping Panel. | NYSAB Business Unit | Within 28 days of notification |
|  |  | * 1. The final decision to conduct a SAR rests with the NYSAB Independent Chair. The Chair may wish to seek peer challenge from another SAB Chair when considering this decision | NYSAB Independent Chair |  |
|  |  | * 1. Discussions should be held on how to inform the adult if alive and/or their representative or immediate family if there is to be a SAR. This should be completed as soon as practically possible. It will ordinarily be confirmed via telephone in the first instance and followed by confirmation in writing. See Appendix 5 | Most appropriate person identified by the SAR Delivery Group. | As soon as practically possible |
|  |  | * 1. The scope of the SAR should be clarified to include sufficient information to enable participating organisations to prepare for the first SAR Delivery Group meeting. The scope of the SAR will also determine the timeframe during which events in the adult’slife will be reviewed, taking into account the circumstances of the case | SAR Delivery Group attendees |  |
| **3.** | **SAR Panel (SARP)** | * 1. The first SAR Delivery Group meeting will review the: * Scope of the SAR * Determine the draft Terms of Reference * Consider a methodology for the review. There is a range of methodology options for conducting Safeguarding Adults Reviews. See Appendix 3. * Arrangements for administrative support. * Identify a Chair | SAR Delivery Group attendees | Within 28 days of the SAR being initiated  Reasonably extended with the permission of the NYSAB Independent Chair |
|  |  | * 1. The SAR Delivery Group should also: * Consider if the SAR Delivery Group will need to obtain independent legal advice about any aspect of the review * Feedback matters concerning family and friends, the public and media to the SAR Subgroup * Ensure that any learning identified at an early stage of the process is shared and acted upon | SAR Delivery Group |  |
|  |  | * A point of contact should be identified for on-going liaison with the adult and/or their representative. This point of contact will be a member of the SAB partnership. The degree of family/representative involvement will be discussed with the individual(s) and agreed at the outset. Consideration will be given to the possible benefits of advocacy | To be identified by the SAR Delivery Group |  |
| **4** | **Timescale for SAR Completion** | * 1. The NYSAB will aim for completion of the SAR within six months of initiating it. Every effort will be made to complete the SAR and identify the learning unless it is impossible to do so without risking interfering with a criminal investigation or court proceedings. | NYSAB Independent Chair | Within six months of initiation |
|  |  | The SAR Subgroup will be notified on the progress of the SAR on a quarterly basis via the NYSAB SAR Tracker. | SAR Subgroup | On-going |
| **5** | **Reports** | * 1. All reports should be pseudononsyed unless the person or their family requests otherwise. Discussion will take place with the adult and/or their family regarding the use of pseudonyms within the report. The report should be written in plain and easy to understand language, provide a sound analysis of what happened and why, and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a reoccurrence. | Independent Author |  |
|  |  | * 1. The Independent Author should present the Final Report to the SAR Subgroup and Board for agreement prior to publication. The agreed documents should then be forwarded to the NYSAB Independent Chair by the Business Unit. | NYSAB Business Unit | On completion of final report |
|  |  | * 1. The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the NYSAB. | Independent Chair |  |
|  |  | * 1. If they are involved, liaison should take place with the adult and/or their representative regarding the final report and allow for feedback | Nominated contact | Prior to publication |
|  |  | The Local Authority will ensure there are appropriate arrangements in place to support the adult and/or family members in preparation for, and following the publication of the report | Nominated contact/NYSAB Business Unit |  |
| **6** | **Sharing the Learning** | * 1. The NYSAB will agree dissemination of overarching learning, e.g. via a 7-minute briefing, spotlight session, etc. Individual agencies are responsible for providing feedback to staff and agencies involved in the case. | Independent Chair |  |
|  |  | * 1. An Action Plan will be created to oversee the implementation of any recommendations/actions | SAR Delivery Group | Immediately prior to publication |
|  |  | * 1. A reason should be given for any decision where the NYSAB cannot or decides not to implement a recommended action | SAR Delivery Group /NYSAB |  |
| **7** | **Publication of Reports** | * 1. All Safeguarding Adults Reviews conducted within the year will be referenced within the North Yorkshire Safeguarding Adults Board’s Annual Report together with any actions that it has taken or intends to take. All reports will use the agreed pseudonym unless family have specified otherwise. The Annual Report will also include the reason for any decision where the NYSAB cannot or decides not to implement an action | NYSAB Business Unit | Annually |
|  |  | * 1. Safeguarding Adults Reviews are written with the aim to publish, together with the associated Delivery Report on its website | NYSAB Business Unit | As required |
|  |  | * 1. The NYSAB will submit SAR publications for inclusion in the national SAR library where appropriate. | NYSAB Business Unit | As required |
| **8.** | **Monitoring** | 8.1 Arrangements for the monitoring of actions plans should be put in place as follows:   1. Individual agency action plans to be monitored by the agency concerned 2. Overall monitoring to be undertaken by the SAR Delivery Group. 3. A report on the implementation of action plans across partnerships to be given to the NYSAB at an agreed frequency via the SAR Subgroup.    1. Liaison to continue to take place with the adult and/or their representative as appropriate | SAR Delivery Group/SAR Subgroup | Following creation of the plan and until all actions are completed. |
|  |  | 1. Family/representatives will be informed of progress against the action plan six months after publication of the SAR | SAR Delivery Group |  |
|  |  |  |  |  |

****

**Safeguarding Adult Review (SAR)**

**Referral Form and Decision Record**

North Yorkshire Safeguarding Adults Board (NYSAB) considers every Safeguarding Adult Referral (SAR) referral based on whether it meets the criteria for a SAR 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:
2. 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**

1. Either of the following conditions are met –
2. Condition 1 is met if –
3. The adult has died, **and**
4. The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knows about or suspected the abuse or neglect before the adult died)
5. Condition 2 is met if –
6. The adult is still alive, **and**
7. The SAB knows or suspects that the adult has experienced serious abuse or neglect.
8. A SAB may also 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).

**How can I refer a case for review?**

* Any professional can make a referral. If you know of a case that may meet the SAR criteria, then in the first place you should discuss a possible referral with the safeguarding lead for your organisation.
* Referrals should be discussed and authorised by your agency’s Safeguarding Lead where applicable prior to submission.
* Referrals should be submitted without delay to [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk) or via post to NYSAB, North Yorkshire Council, County Hall, Racecourse Lane, Northallerton, England, DL7 8AD.
* A member of the public who wishes to make a SAR referral can also do so as above.
* The Board needs as much information as possible to enable members to make a proportionate decision as to how to respond to a SAR referral, ensuring, if the case is accepted for a review, that maximum learning can be achieved. Please therefore complete as much information on this form as possible.
* Referrals will be considered, and the referrer informed of the outcome.

**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** | |
| Date of 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) |  |
| NHS Number |  |
| Ethnicity |  |
| Address |  |
| GP (if known) |  |
| Details of care and support needs of the adult |  |
| Any other relevant protected characteristics |  |

|  |  |
| --- | --- |
| **3. Details of the representative/family of the adult with care and support needs** | |
| Does the adult have any family or representative as far as you are aware? | Yes No (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 meets the criteria for a SAR? | Yes No (if Yes please give details) |
| **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: the adult, the care and support needs, living situation, location of the abuse/incident, type of abuse/safeguarding issue, and the source of risk. If the person is alive, please describe the impact of the alleged abuse.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **6. Please outline the factors that suggest the SAR** [**criteria**](http://www.worcestershire.gov.uk/info/20222/safeguarding_adults/159/safeguarding_adults_reviews) **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 **responding fully to each separate criteria.**  For the circumstances to meet the criteria there must be concerns about how separate agencies **worked together.** | | | | |
| 1. **The adult has care and support needs – Specify below:** | | | | |
|  | | | | |
| 1. **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 which agencies and in what way they did not work together which led to the abuse or neglect.* | | | | |
| 1. **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:* | | | | |
| **Type/s of abuse/neglect identified:** | | | | |
| Discriminatory | Domestic Abuse | Financial | Modern Slavery | Neglect |
|  |  |  |  |  |
| Organisational | Physical | Self-Neglect | Psychological | Sexual |
|  |  |  |  |  |
| 1. **The adult is still alive and suspected to have experienced abuse or neglect:** | | | | |
| *Supporting information to include what the abuse and neglect consisted of:* | | | | |
| **Type/s of abuse/neglect identified:** | | | | |
| Discriminatory | Domestic Abuse | Financial | Modern Slavery | Neglect |
|  |  |  |  |  |
| Organisational | Physical | Self-Neglect | Psychological | Sexual |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **7. Please list the agencies/service providers known to be involved in this case. Please include the GP.** | | |
| Name of Agency | Contact Name | Contact Email |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **8. Please provide any additional information you feel is relevant.** |
|  |

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

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

Signed:……………………….. Print name:…………………………….. Date Authorised: …………

Electronic signatures are acceptable

Signed by Senior Manager/Designated Safeguarding Lead/SAB Member

**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** |
|  |  |  |

**2b Record of Discussion/s at the Scoping Meeting**

|  |  |  |
| --- | --- | --- |
| **Date** |  | |
| **Attended by:** | | |
| **Name** | | **Title & Organisation** |
|  | |  |
|  | |  |
|  | |  |
|  | |  |

|  |  |
| --- | --- |
| **Discussion**  (Record rationale for how the case meets each criterion, including consideration of the factors highlighted for consideration within the Quality Markers) | **Decision** |
| 1. **The adult has care and support needs:** |  |
| 1. **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.** |  |
| 1. **The adult has died (suspected to be resulting from abuse or neglect).** |  |

|  |
| --- |
| **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) of the Care Act 2014 |  |
| ii | Meets the criteria for a SAR under S44 (4) of 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 referral has met the criteria for 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: ..................................................................**

**SAR Subgroup Chair**

**Date: ...................................................................**

**SAB Chair Decision**

|  |
| --- |
|  |

**Signed: ..................................................................**

**Date: ...................................................................**



**Safeguarding Adult Review – Initial Request for Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Adult:** | *Completed by Business Unit from referral* | **Personal Identifier (e.g. NHS number):** | *Completed by Business Unit from referral* |
| **Date of birth:** | *Completed by Business Unit from referral* | **Date of death or serious incident** | *Completed by Business Unit from referral* |
| **Gender** | *Completed by Business Unit from referral* | **Organisation Completing Request** |  |
| **Ethnicity** | *Completed by Business Unit from referral* | **Name of Professional Completing Chronology** |  |
| **Last Known Address:** | *Completed by Business Unit from referral* | **Contact Details – please provide an email and phone number** |  |
| **Summary of case/concerns** | *Completed by Business Unit* | | |

This information request relates to a Safeguarding Adult Review (SAR) referral received for the adult whose details are provided above. The concerns identified relate to suspected abuse or neglect of the adult and potentially how agencies worked together to protect the adult.

We ask that all agencies consult their records on this individual in order to build a greater understanding of the circumstances surrounding this case for discussion at the SAR Subgroup Meeting. It is assumed that the person completing the return will also represent your agency if asked to attend the SAR Subgroup meeting. If this will be another professional, please provide their name, job role and email address.

|  |  |
| --- | --- |
| **Agency Information**  Please review records from two years prior to the significant harm or death noted in the SAR referral as a minimum. Please include a longer timeline if you feel the information is relevant to the SAR criteria or is necessary to provide a better understanding of your agency’s involvement.  When providing information about other agencies/professionals with involvement, please refer to the organisation/team or specific job role rather than naming individuals within this return. | |
| **Is the adult known to your agency?**  **Please include the period known from and to.** The screening meeting will focus on the two year period prior to the serious harm or death, but may consider information outside of this timeframe if relevant to SAR criteria. | **Yes/ No**  **Time period:**  If no, the remaining questions will not be applicable. Please return in a secure manner to: [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk) |
| **Please provide a brief overview of the nature of your agency’s engagement/ involvement with the adult.**  If the adult is alive, please confirm if they are currently receiving services from your agency or a service you commission. |  |
| **Did the adult have care and support needs?**  Please describe any known or indicated care and support needs. This could include health conditions, support for daily living activities or factors that made the adult vulnerable. |  |
| **Do your records include any safeguarding concerns about abuse or neglect. If so, please provide an overview of dates and concerns.**  **Please confirm if a safeguarding referral was made to the local authority** (including date referred). |  |
| **Have you identified any significant relationships, particularly anyone who lived with the adult, provided care or support, or anyone who posed a risk to the adult?**  Please provide details of who and the nature of the relationship. |  |
| **Did you work with or refer to any other agencies related to this adult?** Please note agencies and provide contact details if available. |  |
| **Do your records indicate any other agencies were involved with the adult?** |  |
| **Are you aware of any other learning or investigation processes related to this adult, either planned, ongoing or completed?**  If your agency has undertaken any formal investigation and/or identified any learning, please include any findings. This may include system learning or learning unique to this case. |  |
| **Do you hold any other information about the adult that relates to a) their needs, b) the risk of abuse or neglect including their ability to protect themselves, or c) concerns about how agencies worked together?** |  |
| **In reviewing your records, have you identified any missed opportunities, areas of learning/improvement or any positive or best practice.** |  |

Once complete please return to [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk)



**SAFEGUARDING ADULTS REVIEW (SAR)**

**Decision Support Guidance**

**Introduction**

There is a need to apply and demonstrate a consistent approach to decision making in relation to Safeguarding Adults Reviews notifications. This decision support guidance has been developed specifically to be used by the SAR Subgroup when considering SAR notifications.

**The Care Act 2014**

The Care Act 2014, which came into force in April 2015, created a new legal framework for Adult Safeguarding. This included outlining the circumstances in which Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR). The Care Act further placed a duty on all Board members to contribute to the undertaking of such reviews.

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. The Care and Support Statutory Guidance issued under the Care Act by the Department of Health also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

**Criteria for Safeguarding Adults Review**

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs):

* an adult in the NYSAB area has needs for care and support (whether or not the local authority was meeting any of those needs).

and

* either dies, and the NYSAB 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)

Or

* does not die but the NYSAB knows or suspects that the adult has experienced significant harm.

and

* There are concerns about how agencies worked together to safeguard the adult

The Care Act also states that SABs ‘are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support‘.

**Serious Types of Abuse**

The following table indicates the types of abuse that are considered to be serious in nature and relevant to decision making in relation to SARs.

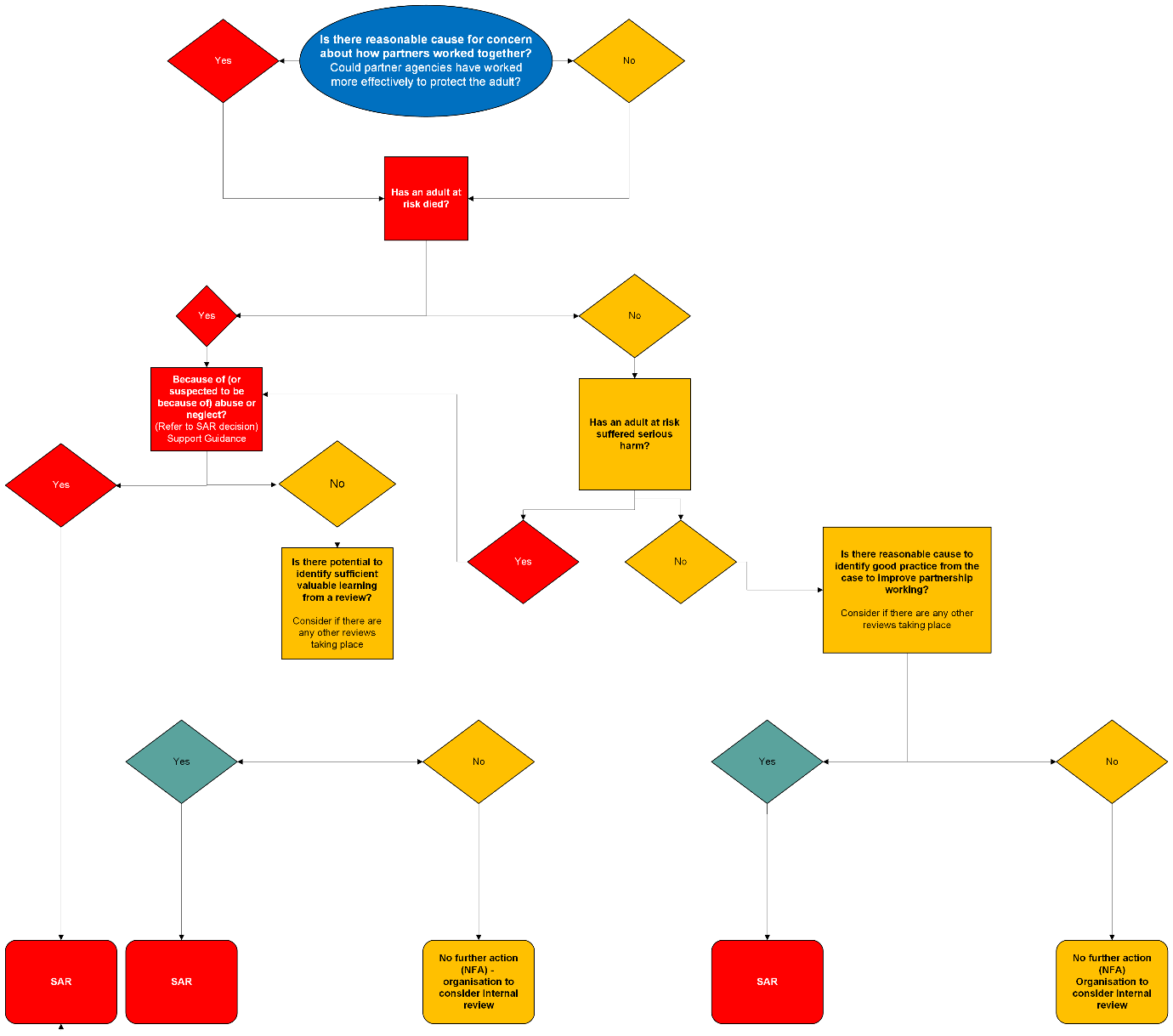
|  |  |  |  |
| --- | --- | --- | --- |
| **Types of Abuse** |  |  | |
| Discriminatory |  | Being refused access to essential services. | Hate crime resulting in attempted murder/murder |
| Domestic Abuse | • | Permanent harm or death due to a lack of response to alleged abuse  domestic abuse | Honour based violence  Please also refer to other categories of abuse; physical, neglect and sexual  Female Genital Mutilation (FGM) |
| Financial | • | Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control. | |
|  | • | Adult denied access to his/her own funds or possessions. | |
|  | • | Fraud/exploitation relating to benefits, income, property or will. | |
| Modern Slavery | • | Incidents of modern slavery resulting in serious injury or death | |
| Neglect and Acts of Omission | • | Ongoing lack of care to the extent that health and well-being deteriorate significantly, for example: pressure wounds, dehydration, malnutrition | |
|  | • | Failure to arrange access to life saving services or medical care | |
| Organisational | • | Staff using their position of power over adults in their care | |
|  | • | Over-medication and/or inappropriate restraint used to manage behaviour | |
|  | • | Widespread consistent ill-treatment | |
| Physical |  | Grievous bodily harm/assault with or without weapons  Inexplicable fractures/injuries  Inappropriate restraint | |
| Psychological/ Emotional | • | Denial of basic human rights/civil liberties in a care/ health setting Vicious/personalised verbal attacks | |
| Self-Neglect | • | Permanent harm or death due a lack of response to reported and/or suspected self-neglect | |
| Sexual | • | Sex in a relationship characterised by authority inequality or exploitation | |
|  | • | Sex without consent (rape) | |
|  | • | Sexual acts against adults as listed in the Sexual Offences Act 2003 | |

**Multi-Agency Working**

When considering a SAR notification (SAR01) the SAR subgroup will need to establish if there were failings from a multi-agency or single-agency perspective. It is important that consideration is given to the increasingly complex landscape of the commissioning and provision of services.



**Safeguarding Adult Review (SAR) - Decision Making Process**



**Types of Review and Methodologies**

The Safeguarding Adults Board should weigh up what type of review process will promote effective learning and improvement to practice. The following principles should be applied when making this decision:

* The approach taken to review a case 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
* 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
* 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 Board should aim for completion of a SAR within a reasonable period of time and in any event within six months of commissioning the IA, unless there are good reasons, for example because of potential prejudice to related court proceedings.

**MENU OF OPTIONS FOR SAR METHODOLOGY**

The menu of SAR methodologies set out below includes the following five options:

A Systems analysis

B Learning together

C Significant incident learning process

D Significant event analysis/audit

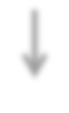
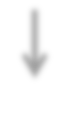
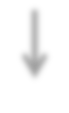
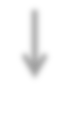
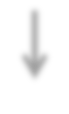
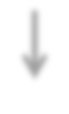
E Appreciative inquiry

On the following pages, a process map of each methodology is provided, along with key features and advantages and disadvantages to assist decision-making. Links are provided to identified available models, which can be used for the most part to download tools and guidance in order to conduct a SAR according to the methodology.

The menu is not an exhaustive list. The SAR Panel members should use its collective experience and knowledge to recommend the most appropriate learning method for the case (including hybrid approaches).

**Option A: Systems Analysis**

|  |  |
| --- | --- |
| **Key features** |  |
| * Team/investigator led * Staff/adult/family involved via interviews * No single agency management reports * Integrated chronology | * Looks at what happened and why,   and reflects on gaps in the system to identify areas for change |



Themes, solutions and achievable recommendations identified  SAR report

Order contributory factors by importance/impact

Analysis to identify contributory factors (service user/ team/management/systems/organisation conditions)

Identify Care/ Service Delivery Problems (specific actions/omissions/slips/lapses in judgement by staff/ volunteers)

Determine the chronology/ story of the incident

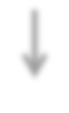
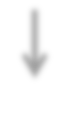
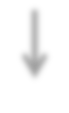
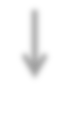
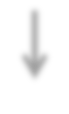
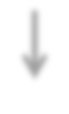
Identify and gather relevant data (e.g. documents, interviews, records, logs etc.)

Choose investigator-led or reviewing team-led model.

Agree interface with SAR panel.

|  |  |
| --- | --- |
| **Advantages** | **Disadvantages** |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers may provide more balanced view * Managed approach to staff involvement may fit well where criminal proceedings are ongoing * Enables identification of multiple causes/contributory factors and multiple causes * Range of pre-existing analysis tools [available](http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/) * Focusses on areas with greatest potential to cause future incidents * Based on thorough academic research and review * RCA tried and tested in healthcare and familiar to health sector SAPB   members. | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions * Staff/family involvement limited to contributing data, not to analysis * Potential for data inconsistency/ conflict, with no formal channel for clarification * Unfamiliar process to most SAPB members * Trained reviewers not widely available * Structured process may mean it’s not light touch * RCA may be more suited to single events/incidents and not complex multi-agency issues |

**Option B: Learning Together**



Underlying system patterns identified and “challenges to the Board” (not recommendations)

Key practice episodes identified, and analysed to identify contributory factors

“Narrative of multi-agency perspectives” produced (not a chronology)

In depth discussion with case group (includes staff/adult/family)

Data and information gathered and reviewed, including via 1:1 conversations with staff/ family (not interviews)

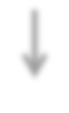
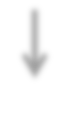
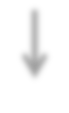
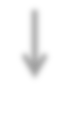
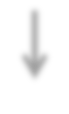
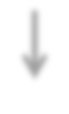
One or two lead reviewers, and a case group identified and prepared. Interface with SAR panel agreed

Research questions rather than fixed terms of eference are identified



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| **Advantages** | **Disadvantages** |
| * Structured process of reflection * Reduced burden on individual agencies to produce management reports * Analysis from a team of reviewers and case group may provide more balanced view * Staff and volunteers participate fully in case group to provide information and test findings * Enables identification of multiple causes/contributory factors and multiple causes * Tried and tested in children’s safeguarding * Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity * Range of pre-existing analysis tools available | * Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions * Challenge of managing the process with large numbers of professionals/ family involved * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses * Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR * Opportunity costs of professionals spending large amounts of time in meetings * Unfamiliar process to most SAPB members * Structured process may mean it’s not light touch |

**Option C: Significant Incident Learning Process**



Final “recall day” to evaluate how effectively the learning has been implemented

Overview report finalised 

SAR report

“Recall day” convened to discuss emerging findings with staff/adult/family involved

Overview report drafted

“Learning day”, with front line staff/adult/ family, discusses the case based on shared written material

Data/materials gathered from individual agencies, through a management report

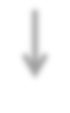
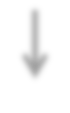
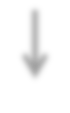
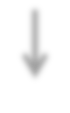
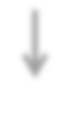
Review team identified and interface with SAR panel agreed

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| **Key features** |  |
| * Team/investigator led. * Staff/adult/family involved via interviews. * No single agency management reports * Integrated chronology | * Multiple learning days over time * Explores the professionals’ view at the time of events, and analysis of what happened and why |

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| **Advantages** | **Disadvantages** |
| * Flexible process of reflection – may offer more scope for taking a light- touch approach. * Transparently facilitates staff and family participation in structured way: easier to manage numbers of participants. * Has similarities to traditional SCR approach, so more familiar to most SAR Delivery Group members * Agency management reports may better support single agency ownership of learning/actions. * Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity | * Burden on individual agencies to produce management reports. * Opportunity costs of professionals spending large amounts of time in learning days * Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses. * Not been widely tried or tested, nor gone through thorough academic research/review |

**Option D: Significant Event Analysis**

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| **Key features** |  |
| * Team/investigator led * Staff/adult/family involved via interviews * No single agency management reports * Integrated chronology | * Multiple learning days over time * Explores the professionals’ view at the time of events, and analysis of what happened and why |



Workshop agreed actions written up by facilitator  SAR report

Workshop asks what happened, why, what’s the learning and what could be done differently

Facilitated workshop analyses data

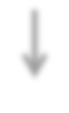
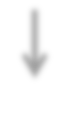
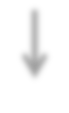
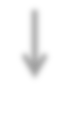
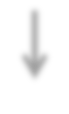
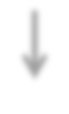
Factual information gathered from range of sources

Facilitator and panel of adult/family/staff involved in the case identified

Terms of reference/ objective agreed

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| **Advantages** | **Disadvantages** |
| * Light-touch and cost-effective approach * Yields learning quickly. * Full contribution of learning from staff involved in the case. * Shared ownership of learning * Reduced burden on individual agencies to produce management reports. * May suit less complex or high-profile cases. * Trained reviewers not required. * Familiar to health colleagues | * Not designed to cope with complex cases * Lack of independent review team may undermine transparency. * Speed of review may reduce opportunities for consideration. * Not designed to involve the family * Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses |

**Option E: Appreciative Inquiry**



Recognition phase – each agency shares good practice internally and endorses practice highlighted from their agency

Strategy phase – whole panel meets to agree how to share the findings with the SAPB  SAR report

Report of discussion sent to manager of each contributing agency

Celebration phase – whole panel discussion to hear from practitioners on what works, including adult’s/family views

Meeting between facilitator and adult/family member to ascertain adult’s/family views

Discovery phase – appreciation of best work done and system conditions making innovative work possible

Terms of reference/objectives agreed. Panel of staff involved in the case identified and a facilitator

|  |  |
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| **Key features** |  |
| * Panel led, with facilitator. * Staff involved via panel. Adult/No family involved via meeting single. * No chronology/management reports | * Aims to find out what went right and what works in the system, and identify changes to make so this happens more often |

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| **Advantages** | **Disadvantages** |
| * Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days. * Staff who worked on the case are fully involved. * Shared ownership of learning * Effective model for good practice cases * Some trained facilitators available * Well-researched and reviewed academic model. * Model understood fairly widely | * Not designed to cope with ‘poor’ practice/systems ‘failure’ cases * Adult/family only involved via a meeting. * Speed of review may reduce opportunities for consideration. * Model not well developed or tested in safeguarding. |



Dear

Re: Name: DOB/DOD: Address:

I am writing to inform you that the North Yorkshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death.

Safeguarding Adult Reviews are undertaken when an adult with care and support needs dies or is seriously harmed, and abuse or neglect is suspected and there are lessons to be learned about the way agencies have worked together to prevent similar deaths or injuries in the future. A Safeguarding Adult Review looks at how local agencies and organisations have worked together to provide services and is completely separate to any investigation being undertaken by the police or Coroner.

If your agency has had involvement, you are likely to be required to be involved in the Safeguarding Adult Review. Your agency may be required to submit documentation and nominate a representative to sit on the Safeguarding Adult Review (SAR) Delivery Group, or alternatively you may be asked to participate in a Case Group or Review Group. This will all be explained once we have the information.

I look forward to hearing from you shortly to enable the SAR Delivery Group to be set up.

Yours sincerely

Independent Chair North Yorkshire Safeguarding Adults Board



A Safeguarding Adult Review (SAR) looks at how local organisations worked together to support the adult at risk at the centre of the review. Safeguarding Adults Boards will carry out a SAR whenever an adult at risk has been seriously harmed or died in circumstances where abuse or neglect is suspected or confirmed and there are concerns that agencies did not work effectively.

In relation to consent, the Care and Support Statutory Guidance states that “informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement”. The Statutory Guidance further states that “where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (for example, because there is a risk that others are at risk of serious harm) and wherever possible the Caldicott Guardian should be involved”.

The following sets out a set of principles based on good practice regionally and nationally that Safeguarding Adult Boards should consider when involving families as part of the SAR process. They should be read in conjunction with the SCIE SAR Quality Markers Checklist (available at https://www.scie.org.uk/safeguarding/adults/reviews/library/apply). Each case will be unique, and it is therefore important that careful consideration is given to the best way of notifying and involving the adult, family and friends.

Considerations

• Safeguarding Adult Boards must have an agreed and documented process for identifying, considering and making decisions on undertaking a Safeguarding Adults Review.

• As part of this process clear consideration should be made at the outset on the potential involvement of families and the Board should be notified of this and clarify how they are to be involved.

• The involvement should be clearly documented in the Terms of Reference for the SAR.

• If a decision is taken to not involve the adult at risk and/or their families, the reasons should be informed by legal advice and clearly documented.

Notification - It will be a very sensitive time for everyone, and consideration should be given at an early stage of the following:

• How the notification will be made.

• The ongoing identified support to those involved (how and who will provide it)

• How they will want to be involved

• The purpose, process and parameters of the SAR been communicated in the most appropriate setting or method to ensure that these can be understood and convey respect to those involved

• Informing the adult or family/friends about how the process works and what role they will have in shaping this.

• Early notification needs to take place with the adult at risk, family/friends to agree how they wish to be involved and how they should be supported. Where appropriate, as a Care Act 2014 requirement, an independent advocate to represent and support the adult through a SAR.

• The timing of such notifications is crucial particularly where there are ongoing police investigations – this decision should be considered by the Board with the police representative present.

• Involving the adult, family and friends can range from formal notification only, to inviting them to share their views with the Independent Author in writing or through interview.

• Be clear to the adult, family and friends who is likely to be involved in the whole process.

• Appoint a key contact, separate from the report author, for the adult, family and friends.

• Provide notification in a way that is appropriate to the individual case i.e. face to face or by letter. (See example letter in below)

• This should be accompanied by a plain English explanatory leaflet (see example below) that sets out the following:

• A description of the Board and its arrangements

• What is a Safeguarding Adults Review

• Why you are carrying out a Safeguarding Adults Review

• Who will carry out the review or how it will be completed if an independent author is not appointed

• What to expect during the review – what will they have to do

• What will happen after the report is finished

• How long the review will take

• The Board must put in place sufficient assurances that there is appropriate involvement in the review process of people affected by the case including where possible the person subject to abuse and their families/significant others.

• Updates must be given at key stages of the review and before the publication of the report. An appropriate person who is connected to the Board and the review must fulfil this role. It is advisable that this person becomes the key contact for the adult, family and friends for any questions and clarification during the process.

• Provide the adult, family and friends with contact details of people with the facility of asking questions, queries or clarifications through the process.

• Draft report shared with family by the IA or most appropriate person identified by the SAR Delivery Group. Detail how long the family will have to comment on the draft report.

• Ensure that the adult, family and friends are given details of how their personal information will be treated and how confidentiality will be adhered to. They must provide written consent to how this will be carried out.

• Where there are criminal investigations and family members are witnesses or suspects, the police senior investigating officer must understand the focus and scope of the review to help discussions about when and how family members can be involved.

Conclusion

• Put in place mechanisms to allow the adult and/or their family to feedback on the report before it is completed. (this may not result in significant changes)

• The key contact must arrange to meet up with the adult, family and friends to discuss the contents of the executive summary.

• Be clear on how families are to be represented in the final report.

• Provide the adult, family and friends a copy of the executive summary of the report. This will include the key findings and recommendations of the review

• Inform the adult, family and friends of next steps of how this will be presented and who will be involved.

• Be clear on how the report will be published and where it will be available.

• Explain that an action plan will be developed to respond to the recommendations made by the report and that its delivery will be overseen by the Safeguarding Adults Board.

• The Safeguarding Adults Board may wish to provide the adult, family and friends an update on progress against the action plan in agreed intervals

**LETTER – Notification to Family Member or Representative**



Date:

RE: XXXXXXX SAFEGUARDING ADULTS BOARD: SAFEGUARDING ADULTS REVIEW

(In the case of a death) Firstly, I would like to offer my sincere condolences on the death of (adult’s name).

The purpose of this letter is to inform you that because of circumstances surrounding XXXX death, the North Yorkshire Safeguarding Adults Board (NYSAB) will carry out something called a Safeguarding Adults Review.

Safeguarding Adults Boards have a duty to carry out a Safeguarding Adults Review (SAR) when an adult dies as a result of abuse or neglect or when an adult has not died but it is known or suspected that they have suffered serious abuse, harm or neglect. and there is information to suggest that partner agencies could learn lessons and improve the way they work together to support adults at risk in the future. The purpose of a SAR is not to apportion blame, but to identify recommendations to promote effective learning and improvement in order to minimise the risk of future deaths or serious harm occurring again.

I would like to reassure you that this Safeguarding Adults Review will not influence any ongoing investigations, or any other work that may be happening at the moment between your family and professionals such as a social worker.

An Independent Author (the person the NYSAB commissions to undertake the SAR) will be in touch regarding the SAR. However, in the meanwhile, please do not hesitate to contact the NYSAB Business Unit if you want to make some comments or observations to the Safeguarding Adults Review or if you would like any further information.

You may want to take independent legal advice before making any decisions about all of this. If your solicitor has any queries, he or she is also welcome to contact the above mentioned person.

Yours sincerely

Copy To:

Independent Author

NYSAB Business Unit

Post:

Email:

Phone:



**Safeguarding Adults Reviews: Information for Families**

If you need this information in another format, please contact; NYSAB Safeguarding Adults Board Support Unit at [nysab@northyorks.gov.uk](mailto:nysab@northyorks.gov.uk) or telephone 01609 780780

**What is NYSAB Safeguarding Adults Board?**

North Yorkshire Safeguarding Adults Board brings together all the main organisations who work with adults at risk and their families in North Yorkshire to keep them safe.

**What is a Safeguarding Adults Review?**

A Safeguarding Adults Review looks at how local organisations worked together to look after the adult at risk at the centre of the review. It may also look at how they are working with other adults with care and support needs in the immediate family or care settings. The review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is not a Criminal Investigation or Public Enquiry, and its aim is not to place blame, but to learn.

**Why Are You Carrying Out a Safeguarding Adults Review?**

NYSAB Safeguarding Adults Board will carry out a SAR whenever an adult at risk has been seriously harmed or has died in circumstances where abuse or neglect is suspected or confirmed.

**Who Will Carry Out the Review?**

A panel of professionals from Community and Adult Care Services, the Health Service, the police and sometimes other organisations are led by an independent person (the ‘Author’). They will meet to review reports from each organisation or agency which has worked with or provided services to the adult at risk or their family. The Independent Author will prepare a report. This report will say what lessons have been learnt and make recommendations for North Yorkshire Safeguarding Adults Board.

**What Will Happen after the Report is Finished?**

NYSAB Safeguarding Adults Board will write an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. NYSAB Safeguarding Adults Board will make sure the actions are carried out and have a positive effect.

**What Will I/We Have to Do?**

You do not have to do anything. However, you will have the opportunity to give your views if you would like to. We will make sure that there is someone who can help you to do this (see contact details below).

**Who Will See the Report?**

Normally the Report will be kept confidential to those people who represent their organisations at NYSAB Safeguarding Adults Board or have contributed to the review and the staff within those organisations who worked with the adult at risk and their family. The Executive Summary sets out the key findings and recommendations of the review. It does not give any personal details or information which would identify the adult at risk, family or anyone else involved. It is available to anyone who wants to read it and will be on our web site. Your personal contact will meet with you and tell you what is in the Executive Summary before it goes on the website.

**How Long Will the Review Take?**

It usually takes six months from the start of the review to publication of the Executive Summary.

In this leaflet we have answered some of the most frequently asked questions families have about Safeguarding Adults Reviews. Of course, each case is different, and you may have other questions you would like to ask. If so, you can call your personal contact.

Your personal contact is (insert name)