"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Safeguarding Adult Review Policy

Version number	Author	Purpose/Summary if Change	Date
0.1	Levi Sinden – TSAB Manager	Initial draft for internal consultation	05/07/17
0.2	Levi Sinden – TSAB Manager	1. Remove Methodology section. 2. Added Appeals section. 3. Question added to the SAR1 form. 4. Liaison with other review Chairs added to TOR	19/07/17
0.3	Levi Sinden TSAB Manager	Draft to Leadership Executive Group for consultation Draft to TSAB for sign off	24/10/17 13/11/17
1.1	Levi Sinden TSAB Manager	Addition to criteria for a SAR at 2.4	22/10/18
2.1	Levi Sinden TSAB Manager	Amended to reflect new guidance regarding information sharing, data requests and storing information.	07/05/19
3.1	Levi Sinden TSAB Manager	Amendment to Related Policies.	09/03/20
4.1	Paula Ward TSAB Manager	Inserted hyperlinks and footnotes Changed heading 3 from establishing a SAR to making a SAR referral Changed non statutory to discretionary in line with national advice Changed SAR criteria to SAR duties in line with national advice New additions 3.5, 4.3, 4.4, 4.5, 4.11, 5.3, 6.1, 6.3, 6.4, 7.2, 7.4, 8.2, 8.4, 9.3, 11.1, 11.2, 11.3, 14.4, 16.3, 16.4, 16.5, 16.6, 17.2, 17.3, 17.4, 18.2, 18.5, 18.6, 18.7 Updated SAR forms and process map	25/08/21

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Related policies:	DH 2019 Care Act statutory guidance SET Safeguarding Adult Guidelines The Rough Sleeping Strategy

Contents

1. Introduction

1.1. Section 44 of the Care Act 2014 specifies that Safeguarding Adults Boards (SABs) have a duty to arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as result of suspected abuse or neglect.

1.2. Reviews must be conducted in line with Section 44 of the Act, however the type of review must be considered in light of individual circumstances and proportionality.

1.3. Specifically, paragraph 14.162 -164 of the Care Act guidance sets out the following:

- 14.*162 SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.*
- 14.163 *SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.*
- 14.164 *The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases*.[1]

1.4. The purpose of this document is to set out how the Thurrock Safeguarding Adults Board (TSAB) will meet its statutory obligations and how individuals and organisations can request a SAR.

1.5. This policy should be considered in conjunction with the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines[2].

[1] DH 2014, Care Act statutory guidance paragraphs 14.162-164
[2] https://www.thurrocksab.org.uk/wp-content/uploads/2020/08/SET-safeguarding-adult-guidelines-FINAL-002-2020.pdf

2. Safeguarding Adult Review duties

2.1. The purpose of any review is to explore how agencies worked together to determine whether an alternative course of action would have prevented the death or serious harm.

2.2. The Act specifies at section 44 that a SAR **must** be conducted in circumstances where the TSAB has concerns about how members of TSAB or other agencies with relevant functions, have worked together to protect an adult in Thurrock, with care and support needs, when:

a) An adult with care and support needs (whether or not those needs are met by the Local Authority) in the Safeguarding Adults Board's (SAB) area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. Or

b) An adult with care and support needs (whether or not those needs are met by the local authority) in the SAB's area has not died, but the SAB knows or suspects the adult has experienced serious abuse or neglect and there is concern the partner agencies could have worked together more effectively to protect the individual.

2.3. A SAB has discretion to conduct 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) where it believes that there will be value in doing so[3]. TSAB will consider reviews for discretionary cases where:

- there is an opportunity to explore good practice that would enhance multi-agency working;
- there are concerns that the policy or practice of one or more agencies may have hindered other agencies' ability to protect the adult, such as information sharing or resources;
- there is concern that an emerging theme may lead to serious harm or death of an adult in Thurrock if not tackled, such as under reporting of particular types of abuse or lack of advocacy;
- The TSAB can also consider conducting a SAR into any incident(s) or case(s) involving adults(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review.

2.4. In line with best practice set out in The rough sleeping strategy, TSAB will consider all cases for a SAR involving deaths of adults that are rough sleeping, who

[3] Care Act 2014, Section 44

a) has died as a result of suspected abuse or neglect, or
b) is still alive but has experienced serious abuse or neglect.

2.5. The adult does not have to have been in receipt of care and support services under the Act, in order for the case to be considered for a SAR.

2.6. The adult does not have to have been the subject of an enquiry made under Section 42 of the Act, in order for the case to be considered for a SAR.

2.7. The SAR Group will consider whether the SAR will provide a learning opportunity that would assist in preventing deaths and serious harm in the future.

3. Making a Safeguarding Adult Review referral

3.1. Any of the following can make an application for a review:

- Any organisation that has worked with the adult
- Any organisation represented on the TSAB
- The adult concerned, their family, advocate, carer, friend, or
- Any other individual acting on the adult's behalf such as a Coroner, MP or elected member.

3.2. All applications must be submitted on form SAR Form 1 (which can be found in appendix 1) and sent to TSAB@thurrock.gov.uk.

3.3. The applicant should consider the SAR duties prior to submitting the referral.

3.4. Upon receipt of a referral, the Board Manager will

a) acknowledge receipt of the notification.
b) inform the Chair of the TSAB and convene a meeting of the SAR Group.

3.5. Once a SAR has been received, the Board will request a summary of involvement from identified partners (see appendix 2 – Form 2 – Partner request information form).

4. Decision making

4.1. Only the TSAB has the authority to commission a SAR.

4.2. The SAR group will meet to consider the application giving consideration to the duties set out at Section 44 of the Care Act.

4.3. A SAR must be commissioned if there is a statutory requirement to do so.

4.4. In cases other than those involving a statutory obligation, SAR Group should carefully consider whether commissioning a discretionary review would be a valuable exercise: i.e. whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focused on those cases that will yield the greatest learning and practice development.

4.5. SAR Group should also consider whether another review or learning process has already commenced that will identify and share lessons to be learned, or which Thurrock SAB could potentially feed into to avoid duplication (e.g. Domestic Homicide Review, Learning Disabilities Mortality Review (LeDeR) or health Serious Incident process), and provide clarity about any governance issues if other processes are involved (See section 16 – Conducting SARs alongside other reviews).

4.6. The SAR Group will make a recommendation to the Chair of the TSAB to:

- Conduct a statutory SAR
- Conduct a discretionary review, or
- Decline the request.

4.7. In the event that a statutory SAR is commissioned, the Chair will consider notifying the following people:

- The person that requested the SAR
- The adult concerned or their family or advocate
- The Chief Executive of Thurrock Borough Council
- The members of the TSAB
- The relevant regulatory body
- NHS England, and
- The Care Quality Commission.

4.8. In the event that the decision is taken to establish a SAR, the TSAB will send notification in writing to the adult, or the adult's family. If the decision is taken to not make contact with the family, a formal record will be made and kept in the SAR folder (see section 8 - Involvement of family).

4.9. In the event that an application for a SAR is turned down, the decision will be recorded in writing, shared with the applicant and the TSAB. A record will be kept in the SAR application folder of who the application was shared with.

4.10. The final decision as to whether to proceed with a statutory or discretionary review lies with the Chair of TSAB.

4.11. Every effort will be made to make decisions on a referral in a timely way.

5. Appeals/Complaints

5.1. In the event that an application for a SAR is turned down, the applicant can appeal the decision by contacting the TSAB Manager. Any challenge to the decision should be made within 28 days of the feedback being received.

5.2. The appeal will be considered within ten working days by senior representatives from the three statutory partners; Thurrock Council, Thurrock Clinical Commissioning Group and Essex Police.

5.3. Complaints about a SAB and/or any of its functions should in the first instance be made to Thurrock Council using the procedure highlighted on the TSAB website[4]. After this stage if unhappy with the response a complaint can be referred to the Local Government Ombudsman. This will include the conduct of a SAR.

5.4. In the event that a SAR or other type of review is commissioned, the process listed under the heading 'Decision Making' will commence.

6. Methodology

6.1. Once the SAR Group have agreed to commission a SAR, they must decide on the most appropriate methodology to use. This must be appropriate and proportional to the case under review and reasons for the methodology will be referenced in the SAR report. The Care Act Statutory Guidance indicates that whatever SAR methodology is employed, the following elements should be in place:

- **SAR Chair** – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience.
- **SAR Panel** – scrutinises information submitted to the review. The panel should be proportionate to the nature and complexity of the review, but should comprise a minimum of three members in addition to a chair with a level of independence from the case under review.
- **Terms of reference** - openly available.

[4] https://www.thurrocksab.org.uk/contact/complaints-and-feedback/

- **Early discussions with the adult and their family, carers and friends** – to agree to what extent and how they would like to be involved in the SAR and to manage expectations. This includes independent advocacy.
- **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**[5] - including the type of abuse.

6.2. Irrespective of the methodology chosen, all reviews should apply the following principles:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews should be weighed against the cost, resource and length of time to conduct the review.

6.3. 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 that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained SAR authors available in-house or nationally for the method selected?
- Can value for money be demonstrated?

6.4. SAR Quality Markers[6] will be referenced in the ToR. They are a tool to support people involved in commissioning, conducting and quality assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs. The Quality Markers are based predominantly on established principles of effective reviews / investigation as well as experience, expertise, and ethical considerations.

[5] DH 2014, Care Act statutory guidance paragraphs 14.167

[6] Social Care Institute for Excellence and Research in Practice for Adults (2018) 'Safeguarding Adult Review Quality Markers Checklist'. London: SCIE.

7. SAR Group/Panel

7.1. The SAR Group is a part of the TSAB governance structure and will only be convened when a SAR application is received and while a SAR is underway.

7.2. Membership of the SAR Group will be senior representatives from:

- Adult Social Care
- Thurrock Clinical Commissioning Group
- Essex Police
- Principal Social Worker
- Voluntary sector
- Legal as and when required
- SAB Board Manager.

7.3. The initial meeting of the SAR Group will discuss the application and decide whether to proceed to a review or decline the application.

7.4. If agreed a SAR Panel will be set up for each SAR (this may be the same members as the SAR Group).

7.5. Membership will be finalised on an individual basis to ensure impartiality.

7.6. Group members can be co-opted by the Chair of the SAR Group/Panel in order to obtain expertise in a particular area.

7.7. Group members should be independent of line management duties of any staff implicated in the case.

7.8. The Chair of the SAR Group/Panel will be responsible for providing updates to the TSAB and ensuring that the report is delivered and published within agreed timescales and expected quality. Please refer to the SAR Panel Terms of Reference for a comprehensive list of duties and governance arrangements at appendix 3.

7.9. The SAR Group/Panel will agree the content of the report, summary and action plan.

7.10. The SAR Group/Panel will make a recommendation to the TSAB with regard to the publication of the SAR report, and ensure that is appropriately anonymised.

7.11. The SAR Panel will nominate a representative to liaise with the family.

7.12. Statutory SARs will be conducted by an individual that is independent of any organisations whose actions are subject of the review.

7.13. Discretionary reviews may be conducted by a person that is associated with the TSAB, but not directly employed by any of the organisations subject to the review.

7.14. SAR authors/Chairs of statutory and discretionary reviews must have the appropriate skills and experience, which should include:

- Strong leadership and ability to motivate others
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- Collaborative problem solving experience and knowledge of participative approaches
- Good analytic skills ad ability to manage qualitative data
- Safeguarding knowledge
- Inclined to promote an open, reflective learning culture[7].

7.15. The TSAB will be responsible for assuring the action plan that supports the findings of the report. Assurance will include obtaining evidence that action has been taken to make service improvements, learning has been embedded and that lessons have been shared across the relevant organisations in Thurrock.

8. Conducting the Safeguarding Adult Review

8.1. Section 45[8] of the Act gives TSAB the authority to request information that is relevant to the investigation. Providing the request is made for the purpose of assisting the investigation and the organisation has the ability to provide the required information, they must comply with the request.

8.2. The Board will request a full chronology and individual Management Report (IMR) from each organisation using Form 3 - Full chronology and Individual Management Report (IMR) (see appendix 4).

8.3. The cost of the SAR will be met from within the TSAB budget.

[7] DH 2014, Care Act statutory guidance paragraphs 14.172
[8] Care Act 2014, Section 45

8.4. The appointment of an independent report writer will be made via requests through all appropriate networks.

8.5. SAR authors will be issued with a contract which includes references to

9. Involving the adult or their family or representative

9.1. Section 14.54 of the Care Act states that an advocate must be appointed to represent and support an adult who has 'substantial difficulty' in being involved in a Safeguarding Adult Review, where there is no suitable alternative person to provide this support.

9.2. Thurrock Council is responsible for securing an advocate and meeting the cost.

9.3. The SAR group will define who constitutes which family members will be involved in the SAR, at what level and who will be the key point of contact.

9.4. Communications with the family will be decided and agreed on a case by case basis to meet the needs of the individuals and families involved.

9.5. The representative with responsibility to liaise with the family will maintain contact with the adult or family throughout the investigation. They will share the SAR report with the family, and agree a publication date where relevant, taking into account any sensitivities such as date of death. The frequency and method of communication will be based upon the needs and wishes of the family/representative.

9.6. The consent of the adult, or their family or representative is not required in order for the SAR to take place.

10. Involving staff

10.1. Staff that have worked directly with the adult involved should be notified by their employing organisation that a SAR will be undertaken on a case that they were involved in.

10.2. TSAB/SAR author should contact the organisation to seek involvement of their staff member in the review.

10.3. Staff should be offered support in line with their organisation's HR policies.

11. Cross boundary working

11.1. 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 not in the SABs 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. Early consideration should be given inviting a representative from the SAB of the funding area to participate in the SAR. The SAB representative from the funding area has the responsibility of sharing all learning and ensuring and recommendations/ actions for their area are implemented within agreed timescales.

11.2. Upon receipt of a SAR referral that relates to an adult from another local authority area, the TSAB Manager should notify the TSAB Independent Chair and then consult with the appropriate SAB to determine the most appropriate means of sharing information.

11.3. The TSAB team will help to facilitate information gathering, on behalf of other local authorities, for the purpose of any SAR that is conducted.

12. Allegations of misconduct

12.1. The review will not explore whether an organisation or individual is responsible. Existing criminal, disciplinary and regulatory processes exist for this purpose, and where relevant, additional investigations will commence before or alongside the SAR.

12.2. The SAR is not intended to apportion blame or manage allegations against staff. If an issue of this nature arises, the member of staff will be managed under the employing organisation's HR processes, and in line with the Local Area Designated Officer (LADO) policy.

13. Timescales

13.1. The SAR author will be responsible for ensuring completion of the SAR and sharing the report within the recommended six months from the date that the SAR commences. If the SAR author believes that this is not possible, due to potential prejudice regarding related criminal proceedings, an alternative timescale should be agreed with the Chair of the SAR Panel.

13.2. The SAR Panel will monitor compliance with the agreed timescales.

14. Sharing information

14.1. Section 45 of the Care Act places a legal duty on organisations to comply with requests for information that are received from Safeguarding Adults Boards that assist with reviews.

14.2. Organisations are still required to give due consideration to the Data Protection Act 1998 and General Data Protection Regulation, but this should not be used as a reason to withhold information.

14.3. Sensitive and person identifiable information will only be shared by secure email, or using encrypted technology where the recipient does not have a secure email account, such as family members.

14.4. Organisations should be aware that information that is submitted to the TSAB will be shared with the SAR author as well as SAR panel members.

15. Accountability

15.1. Terms of reference will be agreed for each review, approved by the Chair of the TSAB. They should:

- Include reference to the six safeguarding principles
- Be anonymised or consent should be sought if records are to include identifiable information. If using a pseudonym, this should be agreed with the family where appropriate.
- Be made available to the public on the TSAB website.

15.2. TSAB will include findings from any SAR undertaken within its annual report, along with progress in implementing the recommendations. If TSAB decides not to implement one or more of the recommendations, an explanation will be given.

16. Publication

16.1. In the interests of transparency TSAB will publish SARs unless there is reason not to and will be on a case by case basis.

16.2. Consideration will be given to the public interest, legal advice and confidentiality. This may mean that some sections of the report are redacted.

16.3. Published SARS or the findings will be included in the TSAB annual report (para 4(1)(d) of schedule 2, Care Act 2014).

16.4. Prior to publication, the SAR Report will be quality assured for factual and legal accuracy by a lawyer, as well as the SAR Panel.

16.5. Planning for the publication of a SAR should start early, ideally at the point the agencies involved in the SAR have been identified. Communications about a SAR will be decided on a case by case basis but all cases will be supported by a press statement which will be shared with all relevant partners.

16.6. Once a date for publication of the SAR has been agreed, a statement should be drafted by TSAB alongside the Local Authority Communications Team, as appropriate.

17. Records and retention

17.1. All SAR applications and subsequent documents will be stored in a secure electronic folder.

17.2. The TSAB is responsible for keeping a record of all cases that have been referred and considered for a SAR.

17.3. Material generated by the SAR process is third party material and belong to the agency supplying them. Therefore requests for information should go directly to the agency and not TSAB.

17.4. Records will be retained for 8 to 10 years in line with Thurrock Council document schedule.

18. Conducting a SAR alongside other reviews

18.1. This policy acknowledges the interfaces with other organisations, particularly those with a statutory responsibility to investigate specific types of incidents which may involve the delivery of healthcare and therefore can coincide with serious incident investigations led by the health service. In doing so, it recognises that a variety of investigation methodologies may be applied and promotes the

ever increasing need to work collaboratively in an effort to draw lessons to inform systematic learning and improvement.

18.2. Ideally, only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties. It may be helpful when running a parallel process to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff.

18.3. There may be a criminal investigation underway, a coroner's inquest scheduled or other statutory investigation that has commenced such as a Domestic Homicide Review or Serious Incident investigation. This should not stop a referral being made.

18.4. In Health, the other statutory investigation framework is Serious Incident (SI): https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf. Following a serious incident, active consideration should be made as to whether or not a referral for a safeguarding adult review is required. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

18.5. The Learning Disability Mortality Review programme (LeDeR programme) has been implemented to review the deaths of people with a learning disability. Whilst this type of review is not statutory, key learning will be gleaned from such investigations and should be taken into consideration if one is running alongside a SAR.

18.6. Domestic Homicide Reviews (DHR) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Domestic Homicide Reviews are multi-agency reviews of the circumstances in which the death of a person aged 16 or over, has or appears to have resulted from violence, abuse or neglect by:

- A person whom he/she was related or had been in an intimate personal relationship, or
- A member of the same household.

The purpose of the review is to identify what lessons are to be learned from the domestic homicide, particularly the way in which local professionals and organisations work individually and together to safeguard victims; and how the lessons will be acted on. Where domestic homicide is suspected in a person with care and support needs, the SAR Panel Chair should contact the Chairperson of the local Community Safety Partnership Board to agree a plan for joint review.

18.7. A coroner is an independent judicial office holder, appointed by a local council. Coroners investigate deaths that have been reported to them if it appears that

- The death was violent or unnatural.
- The cause of death is unknown.
- The person died in prison, police custody, or another type of state detention, including having a Deprivation of Liberty order.

The role of the coroner is to determine who the deceased person was and how, when and where they came by their death. When the death is suspected to have been either sudden with unknown cause, violent, or unnatural, the coroner decides whether to hold a post-mortem examination and, if necessary, an inquest. An inquest is a public court hearing held by the coroner in order to establish who died and how, when and where the death occurred. Where a death has been referred to the Coroner for investigation, the SAR author, SAR Panel chair or TSAB manager should contact the local Coroner's Officer and agree a plan for the SAR. In the majority of cases, the SAR process can go ahead, and would be informed by the results of the post-mortem examination.

18.8. The SAR author/Chair will be responsible for making contact with the Chair of any other review in order to avoid duplication, explore the feasibility of jointly commissioning certain aspects of the review and aligning the reviews where practical.

18.9. Where relevant the SAR author should seek advice from the police or Crown Prosecution Service (CPS) to ensure that the review will not prejudice criminal proceedings. The police or CPS will be responsible for advising whether the review should be postponed until the criminal case is concluded.

19. Learning from Safeguarding Adult Reviews

19.1. The SAR report is considered final when signed off by the Chair of the TSAB.

19.2. The TSAB Manager will ensure that the SAR report will be presented to the TSAB as soon as is practical after sign off. If this does not fit in with the existing meeting schedule, the Chair of TSAB may call an extraordinary meeting of the TSAB.

19.3. The Audit Group has responsibility for assuring that actions identified within the report are completed, and will seek evidence to demonstrate that learning has been embedded within the organisation.

19.4. The TSAB will escalate issues of non-compliance regarding the actions to the relevant organisation.

19.5. Where appropriate the SAR report will be published on the TSAB website to allow other SABs to learn from our experience.

19.6. The SAR will only be closed when the TSAB is satisfied that all actions from the SAR action plan has been completed and embedded into practice.

Appendix 1 – SAR Form 1

"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Safeguarding Adult Review Request Form

The Safeguarding Adult Review Group of the Thurrock Safeguarding Adult Board (TSAB) considers every referral on the basis of whether it meets the duties for a Safeguarding Adult Review (below). For further information please see the Safeguarding Adult Review policy (*link*) or contact the Safeguarding Adults Board Manager at TSAB@thurrock.gov.uk or 01375 659713.

Mandatory reviews (Section 44(1-3)) Care Act 2014

TSAB 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 TSAB, its members or organisations worked together to safeguard the adult

AND

b) The person died and TSAB knows or suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

c) The person is still alive but TSAB knows or suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

The Care Act guidance outlines that in the context of SARs something can be considered as 'serious abuse or neglect' where, for example:
• the individual would have been likely to have died but for an intervention
• the individual has suffered permanent harm
• the individual has reduced capacity or quality of life (whether because of physical or psychological effects)
• the individual has suffered serious sexual abuse.

Discretionary reviews (Section 44(4)) Care Act 2014

TSAB may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support (whether or not the local authority has been meeting any of those needs). These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, but which may not meet duties for a Safeguarding Adult Review.

Please complete all sections and include as much information as possible to enable TSAB members to make a decision. The completed referral must be reviewed and authorised by a senior manager and submitted to the TSAB in a confidential manner to TSAB@thurrock.gov.uk.

1. Referrers details	
Name	
Role	
Organisation name	
Organisation address	
Telephone number	
Email address	

2. Details of the adult subject of this referral			
First name			
Surname			
Address			
Date of birth			
Date of death (where applicable)			
Ethnicity			
GP name			
GP practice and address			
NHS number (if known)			
Details of adults care and support need			
Has a safeguarding concern been raised regarding the adult?	Yes	No	Unsure
Has the adult been the subject of a S42 enquiry	Yes	No	Unsure
Mental Capacity Assessment completed	Yes	No	Unsure
Subject to a DoLS?	Yes	No	Unsure

Detained under the Mental Health Act?	Yes	No	Unsure
Subject to 117 (Mental Health Act)	Yes	No	Unsure
Subject to Guardianship	Yes	No	Unsure
Lasting/Enduring Power of Attorney registered	Yes	No	Unsure
Are criminal proceedings underway?	Yes	No	Unsure
Has another review been commissioned, such as a Domestic Homicide Review or Serious Incident?	Yes	No	Unsure
Please give details:			

Category of alleged abuse (if any):	☐ Physical	☐ Sexual
	☐ Psychological or emotional	☐ Self neglect
	☐ Financial	☐ Modern slavery
	☐ Domestic abuse	☐ Organisational
	☐ Neglect or acts of omission	☐ Discriminatory

3. Details of the adults representative/family		
Does the adult have any family or representative as far as you are aware?	Yes	No
Are they aware of the SAR referral?	Yes	No
Family member/representative name		
Contact details		
Relationship to the adult		

4. Details of the person(s) or organisation alleged to have caused harm or neglect	
Name (individual or organisation)	
Date of birth (where applicable)	
Address	
Relationship to the adult	

5. Agencies involved with the adult Please give details
Please give details:

6a. Please explain how this case meets the duties for a statutory SAR		
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	Yes	No
Supporting information:		
The adult has died, and there is a suspicion that the death resulted from serious abuse or neglect or	Yes	No
Supporting information:		
The adult is still alive, and there is suspicion that the adult has experienced serious abuse or neglect	Yes	No
Supporting information:		

6b. Please explain how this case meets the duties for a discretionary review		
The case provides an opportunity to learn from good practice that could be applied to agencies working with adults	Yes	No
Supporting information:		
Whilst there are no concerns about the multi-agency working to protect the adult, there is evidence that one or more of the agencies involved did not support this joint working	Yes	No
Supporting information:		

7. Any other supporting information
Please give details:

Please send this form to TSAB@thurrock.gov.uk

Appendix 2 – SAR Form 2 - Partner request information form

"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Initial Scoping and Information Sharing

Thurrock Safeguarding Adult Board (TSAB) has received a Safeguarding Adult Review (SAR) application. In order to decide whether the SAR should proceed, the TSAB SAR group requires the information about whether you have had contact with the adult and a summary of interactions.

The Act specifies at section 44 that a SAR **must** be conducted in circumstances where the TSAB has concerns about how members of TSAB or other agencies with relevant functions have worked together to protect an adult in Thurrock, with care and support needs, in the following circumstances:

a) There is reasonable cause for concern about how the Safeguarding Adults Board (SAB), members of it, or other organisations worked together to safeguard the person, **And**
b) The person has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). **Or**
c) The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect.

The Care Act guidance, paragraph 14.163 provides advice regarding the circumstances in which TSAB must conduct a SAR for an adult who is still alive.

An 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).[9] TSAB will consider reviews for discretionary cases where:

- there is an opportunity to explore good practice that would enhance multi-agency working;
- there are concerns that the policy or practice of one or more agencies may have hindered other agencies' ability to protect the adult, such as information sharing or resources;
- there is concern that an emerging theme may lead to serious harm or death of an adult in Thurrock if not tackled, such as under reporting of particular types of abuse or lack of advocacy.

[9] Care Act 2014, Section 44

Section 45[10] of the Act gives TSAB the authority to request information that is relevant to the investigation.

This should be completed by a Safeguarding Lead within your organisation. This initial scoping and information sharing form should, therefore, be returned to us by (insert date).

Case reference:

Details of the Adult	
First name	
Preferred name	
Surname	
Address	
Date of Birth	
Date of Death (if applicable)	
Ethnicity	
Your details	
Your name	
Your role	
Agency name	
Agency address	
Your telephone number	
Your email address	
Summary of your agency involvement with the case	
List of Agencies / Professionals involved	
Are there any areas for concern around partnership working?	
Are you aware of the involvement of any other agencies/parallel processes/reviews? If yes, please give details.	
Please include any further relevant information that you wish to bring to the attention of the SAR Panel.	

[10] Care Act 2014, Section 45

Appendix 3 – SAR Panel Terms of reference

"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Safeguarding Adults Review: Mr or Mrs Letter

Terms of Reference – To be tailored

1. Introduction

This review concerns (insert Mr or Mrs and a letter):

A few bullet points covering the main concerns about the adult.

2. Legal framework

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

The Care and Support Statutory Guidance states that SARs should seek 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. Its purpose is not to hold any individual or organisation to account.

The TSAB SAR Panel considered the case referral for (Mr or Mrs letter) on (insert date of meeting) and concluded that the above duties had been met. The recommendation to commission a SAR was approved by the TSAB Independent Chair on (insert date).

3. Scope

The SAR will cover the following timeframe: (insert date) to (insert date). Relevant information from prior to this period will be taken into account.

The SAR will address the following key questions:

Add in questions

- To explore the effectiveness of how the different agencies involved (or should have been involved) worked together to safeguarding the individual including (as applicable):
    - communications, policies and systems for sharing of relevant safeguarding information between identified providers of services and how effectively communication actually took place, relative to those systems;
    - policies as to the responsibilities of the different agencies where a multiple agency response to a given situation may be involved and how effectively those policies were understood and implemented in the given circumstance; and
    - polices and systems for discussion, challenge and effective resolution of disagreements between professionals from different agencies involved and how effectively those policies were understood and implemented in the given circumstances.
- To determine the levels of authority in decision making between partner agencies involved in the incident.
- To examine if existing policies align in respect of areas relevant to the incident.
- To consider if the following had an impact to the incident
    - the appropriateness of particular actions/practices
    - resource availability
    - practices of supervision, oversight and training
    - monitoring was at a sufficient level
- To consider if the recommendations of any relevant previous inquiries were complied with by all agencies.
- To make recommendations for improvements, which agencies can use to inform existing policies and practice.

4. Agencies involved

- Insert list of agencies involved

5. Links to other reviews

Insert information about any other reviews

6. Methodology

The review will gather agency chronologies in a manner that a multi-agency chronology can be formed.

7. Independent author

The Independent Author for the SAR is TBC.

8. Membership of SAR Panel

A multi-agency SAR Panel will be appointed to oversee the delivery of the SAR.

Member	Role/Agency
Chair	

9. Administration

The SAR Panel will be supported by the TSAB Manager and Administrator. All personally identifiable information will be exchanged using secure methods.

10. Accountability

The SAR Panel is responsible for defining clear terms of reference for the SAR and for establishing the SAR Panel. The TSAB has ultimate responsibility for signing off the SAR and agreeing any recommendations.

11. Involvement of family members

The adult's family will be given the opportunity to contribute their views and experiences to the SAR. They will also be given the opportunity to view the report prior to publication. The (insert job role) will be the single point of contact with the family in relation to the SAR.

12. Timescales

The review will aim to complete its report within 6 months and publish a summary of the learning and recommendations within 8 months. Key dates will be as follows:

Milestone	Date
Scoping and Terms of Reference approved	
Independent Author and SAR Panel appointed	
Chronologies completed	
First SAR Panel meeting	
Meeting with family	
Final draft of report	
Final draft of report presented to SAR Panel/Group	
Share final report with family	
Report presented to TSAB	
Publication	

13. Publication

The report will be written for publication. In the interest of transparency and disseminating learning TSAB will publish the SAR report unless this is not possible

for reasons of confidentiality. References to individuals will be anonymised within the SAR report and will be referred to as an alias. An Executive Summary along with a learning briefing for practitioners will also be published on the TSAB website. The findings from the SAR will also be referred to in the Annual Report.

14. Legal advice

Legal advice will be supplied by Thurrock Council in the first instance unless a conflict of interests should arise, in which case independent legal advice will be sought.

15. Media

A shared position statement will be agreed between all TSAB agencies prior to publishing the SAR report. Media enquiries will be managed through Thurrock Council's press office.

16. Confidentiality

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the SAR Panel or SAR Panel Chair.

These Terms of Reference have been drawn up by the TSAB SAR Panel in consultation with key agencies and the TSAB Independent Chair.

Version 1 (confidential) as agreed by TSAB SAR Panel (insert date).

Appendix 4 – SAR Form 3 – Full chronology request & Individual Management Report (IMR)

"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Safeguarding Adult Review – Full chronology request

Thurrock Safeguarding Adult Board (TSAB) has received a Safeguarding Adult Review (SAR) application in which your agency is cited as having provided services or had contact with the adult involved. The SAR Group have agreed to proceed and conduct a review into the case therefore your agency is being asked to provide a full chronology of your agency involvement with the adult.

The Act specifies at section 44 that a SAR **must** be conducted in circumstances where the TSAB has concerns about how members of TSAB or other agencies with relevant functions have worked together to protect an adult in Thurrock, with care and support needs, in the following circumstances:

d) There is reasonable cause for concern about how the Safeguarding Adults Board (SAB), members of it, or other organisations worked together to safeguard the person, **And**
e) The person has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). **Or**
f) The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect.

The Care Act guidance, paragraph 14.163 provides advice regarding the circumstances in which TSAB must conduct a SAR for an adult who is still alive.

An 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).[11] TSAB will consider reviews for discretionary cases where:

- there is an opportunity to explore good practice that would enhance multi-agency working;

[11] Care Act 2014, Section 44

- there are concerns that the policy or practice of one or more agencies may have hindered other agencies' ability to protect the adult, such as information sharing or resources;
- there is concern that an emerging theme may lead to serious harm or death of an adult in Thurrock if not tackled, such as under reporting of particular types of abuse or lack of advocacy.

Section 45[12] of the Act gives TSAB the authority to request information that is relevant to the investigation.

We would like to focus on your contact with the adult between (insert dates). However, please include information from outside this time period if you feel it is relevant to the case.

Case reference:

Details of the Adult	
First name	
Preferred name	
Surname	
Address	
Date of Birth	
Date of Death (if applicable)	
Ethnicity	
Your details	
Your name	
Your role	
Agency name	
Agency address	
Your telephone number	
Your email address	
Your agency's chronology **Provide your agency contact with the adult in chronological order for the time period specified above, include the date of commencement and completion of service.**	
Date (please use 08.01.78 format)	**Event/Reason (please include any actions taken/decisions made)**

[12] Care Act 2014, Section 45

"*To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"*

Independent Management Report (IMR)

IMR for: Name - DOB/DOD

The period to be covered by the review will be XXXX to XXXX.

- **Please use real names of those involved when completing this IMR as these will be anonymised for the final overview report.**

- **Please also adhere to Data Sharing policies for sharing restricted information/documents.**

Details of the Author	
Your name	
Your role	
Agency name	
Agency address	
Your telephone number	
Your email address	
Completion date	
Author Signature	

- ***It is the responsibility of the signatory of this report to ensure that all information provided is true and accurate to the best of your knowledge.***

Senior Approval/Sign Off	
Name	
Role	
Date	
Signature	

1. INTRODUCTION

1.1 Reason for Review

**To be added in.*

1.2 Terms of Reference

*Please see attached Terms of reference.

1.3 Details of parallel reviews/processes

**Insert any details of parallel processes/reviews that may be taking place.*

1.4 Contextual Information

Consider how the service was delivered at the time of the incident and how it is delivered presently. Examples of the type of information that would be useful are as follows:

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organisational change
- Unallocated cases
- The social and community context
- Management and supervision
- Risk management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal advice
- Findings of any audits or inspections
- Significant national/Local policy changes.

1.5 Methodology

Record the methodology used including extent of document review and interviews undertaken including:

- How the agency carried out the review.
- Details of documents seen.
- List of interviews and dates.
- List of interviews and dates (a written record of interviews should be made and shared with interviewee).
- Details of information not available/not considered (with reasons).
- Details of how agency staff were kept informed of the purpose and process of the Individual Agency Review.
- Details of staff involved by name and job title for the benefit of the Panel only. The overview report will be completely anonymised.

2. FAMILY COMPOSITION

Please include any family and non-family members who are significant to the case under review (if known).

Name	Gender	Date of Birth	Relationship	Ethnic Origin	Address

3. Summary of involvement

A short summary/narrative of agencies involvement of key events with the full Chronology as an appendix over the period of time set out in the review's terms of reference. State when the victim/family/perpetrator was seen including antecedent history where relevant.

Identify the details of the professionals from within your agency who were involved with the victim, family, perpetrator and whether they were interviewed or not for the purposes of this IMR.

4. Analysis of Involvement

Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.

Address terms of reference specifically but also consider further analysis in respect of key critical factors, which are not otherwise covered by the terms of reference. Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above. Areas of consideration:

- How did agencies work together? Please comment as necessary.
- What problems were experienced in the preparation of the report?
- Were practitioners sensitive to the care needs of the adult in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about an adult?
- Did the agency have in place policies and procedures for safeguarding adults and acting on concerns about their welfare?
- Were the internal adult safeguarding procedures appropriate?
- Were the decisions and actions taken in line with policies and procedures within the agency?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the adults involved? Do assessments and decisions appear to have been reached in an informed and professional way?
- When, and in what way, were the adult's wishes and feelings ascertained and considered? Was this information recorded?

- Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult?
- Were more senior managers, or other agencies and professionals, involved at points where they should have been?
- Was the work in this case consistent with agency and SET policy and procedures for safeguarding adults and wider professional standards?

5. Detailed factual chronology (Please use Chronology Template)
This should include any inter-agency contact as well as key actions and events that took place.

6. Effective practice/Lessons learnt
What do we learn from this case?

- Comment upon changes to guidance / working practises that has changed which would have mitigated this.
- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children and adults?
- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?
- Are there implications for current policy and practice?
- Information sharing.

7. Recommendations
Recommendations should be focussed on the key findings of the IMR and be specific about the outcomes which they are seeking. Recommendations identified that concerning other agencies can be reported to the panel for consideration. IMR recommendations must be SMART (Specific, Measurable, Achievable, Realistic and Timely) and should include:-

- What changes (if any) could be made to your agency's procedures?
- What changes (if any) could be made in inter-agency working in the light of this case?
- What action within the agency should be taken in the light of its findings, and in what timescale?
- What areas of good practice are there? Could these be expanded or practice improved?
- What action should be taken by whom and by when?
- What outcomes should these actions bring about, and in what timescales?
- How will the agency review whether they have been achieved?
- Are there any immediate statutory requirements for the notification of concerns and are they likely to be any media handling issues.

Appendix 5 – SAR process map

"To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities"

Safeguarding Adult Review (SAR): Process on a page

If you are concerned that an adult has died, or would have died (if it were not for intervention), as a result of abuse or neglect, it may be beneficial to review the circumstances to reduce the likelihood of it happening again. For further information read our SAR Policy or discuss with the TSAB Manager.

Four weeks from SAR request

- **Complete SAR1 & send to TSAB@thurrock.gov.uk**
- **TSAB arranges meeting of SAR Group**
- **TSAB Manager agrees initial partnership requests with Chair of SAR Group**
- **TSAB Manager requests a summary of involvement from partner agencies**
- **SAR Group reviews the request and supporting information**

Six months from SAR commencing

- **SAR request declined**
  - **TSAB Manager discusses with TSAB Chair**
  - **TSAB Manager notifies SAR applicant & TSAB members**
- **SAR (S.44 enquiry) agreed**
- **Discretionary review agreed**

TSAB Manager sets up SAR Panel

SAR Panel agrees

- **Terms of Reference**
- **Timescales**
- **Methodology**
- **If independent SAR Author is needed**

TSAB Manager requests agency chronology/IMR

SAR Author/TSAB Manager notifies adult/relatives

SAR Panel periodically review progress

SAR Panel approves final report & action plan

TSAB Chair signs off final report & action plan