"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:	5.1
Status:	Final
Author / Lead:	Paula Ward – TSAB Manager
Ratified By and Date:	TSAB
Effective From:	1/8/22
Next Review Date:	1/08/23
Related policies:	DH 2019 Care Act statutory guidance SET Safeguarding Adult Guidelines The Rough Sleeping Strategy

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
5.1	Paula Ward TSAB Manager	Changes to 3.9, 4.2, 4.3, 5.1, 7.2, 12.4, 15.1, 15.4, 15.5, 16.2, 19.5, 20.1 New additions 4.4, 5.2, 5.3, 5.4, 7.12, 12.5, 12.6, 13.1, 13.2, 13.3, 13.4, 14.1, 15.2, 15.6, 16.3, 19.6, 19.7, 20.3 Appendix 5, 7 Updated SAR forms	Aug 22

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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/information-and-resources/policies-procedures/

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 Care Act section 44(1-3) specifies the Board has a mandatory duty to conduct a SAR 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 (section 44(4)) 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

a) has died as a result of suspected abuse or neglect, or

b) is still alive but has experienced serious abuse or neglect.

[3] Care Act 2014, Section 44

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. SAR Group/Panel

3.1. The SAR Group is a part of the TSAB governance structure and will only be convened when a SAR referral is received and while a SAR is underway.
3.2. Membership of the SAR Group will be senior representatives from:
- Thurrock Council - Adult Social Care
- Thurrock Clinical Commissioning Group
- Essex Police
- Thurrock Council - Principal Social Worker
- EPUT
- Voluntary sector
- Legal as and when required
- SAB Board Manager.

3.3. The initial meeting of the SAR Group will discuss the referral and decide whether to proceed to a review or decline the referral.
3.4. If agreed a SAR Panel will be set up for each SAR (this may be the same members as the SAR Group).
3.5. Membership will be finalised on an individual basis to ensure impartiality. Group members can be co-opted by the Chair of the SAR Group/Panel to obtain expertise in a particular area. Group members should be independent of line management duties of any staff implicated in the case.
3.6. 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.
3.7. The SAR Group/Panel will agree the content of the report, summary and action plan and will make a recommendation to the TSAB with regard to the publication of the SAR report, and ensure that is appropriately anonymised.
3.8. The SAR Panel will nominate a representative to liaise with the family.
3.9. Where appropriate, SARs will be conducted by an individual that is independent of any organisations whose actions are subject of the review.
3.10. 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[4].

3.11. 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.

4. Making a Safeguarding Adult Review referral

4.1. Any of the following can make a referral 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
- Any other individual acting on the adult's behalf such as a Coroner, MP or elected member.

4.2. All referrals must be submitted in a timely manner on form SAR Form 1 (which can be found in appendix 1 and on the TSAB website) and sent securely to TSAB@thurrock.gov.uk. If there is a delay in submitting the referral the reason should be noted.

4.3. The applicant should consider the SAR duties prior to submitting the referral. If the referrer wants to discuss appropriateness of the referral first the Board Manager may be contacted.

4.4. Professionals should ensure that senior management endorses the referral.

4.5. 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.

5. Scoping

5.1. 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). Agencies must complete the request and return it to TSAB within 10 working days. The Care Act s45[5] enables the Thurrock Safeguarding Adults Board to request relevant information from anyone, to support the SAB in undertaking a SAR.

5.2. Agencies involved should secure case records to guard against loss or interference, whist still enabling professional duty to be carried out. All reports

[4] DH 2014, Care Act statutory guidance paragraphs 14.172
[5] https://www.legislation.gov.uk/ukpga/2014/23/section/45/enacted

must indicate their confidential nature and be securely shared in accordance with each agency's information governance procedures.

5.3. Upon receipt of the information requested through scoping the Board Manager will compile a report for the SAR panel, including types of abuse, care and support needs and the principles of Making Safeguarding Personal.

5.4. In accordance with Section 44 Care Act 2014 and its Statutory Guidance the report enables:

- facts to be established, (as far as possible at that point), and if enough information has been gathered
- decisions in relation to any immediate safeguarding intervention that may need to be made and identification of any immediate safeguarding improvements
- the sharing of immediate learning
- decisions on next steps i.e. to undertake a Safeguarding Adult Review or not, or to undertake an alternative review.

6. Sharing information

6.1. 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.

6.2. 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.

6.3. 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.

6.4. 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.

7. Decision making

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

7.2. The SAR group will meet to consider the referral giving consideration to the duties set out at Section 44 of the Care Act and the Equality Act 2010.

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

7.4. 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.

7.5. 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 on Conducting SARs alongside other reviews).

7.6. The SAR Group will make a recommendation to the Chair of the TSAB to:
- Conduct a statutory SAR under the mandatory duty
- Conduct a discretionary review
- Recommend a single agency review (where the duty is not met)
- Decline the request including reasons why.

7.7. 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.

7.8. 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.

7.9. In the event that a referral 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 folder including who the referral was shared with.

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

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

7.12. Where the SAR Group have any concerns about immediate safety these will be raised with the relevant organisation.

8. Appeals/Complaints

8.1. In the event that a referral 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.

8.2. 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.

8.3. 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[6]. After this stage if unhappy with the response a complaint can be

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

referred to the Local Government Ombudsman. This will include the conduct of a SAR.

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

9. Cross boundary working

9.1. 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.

9.2. 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.

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

10. Conducting a SAR alongside other reviews

10.1. 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.

10.2. 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.

10.3. 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.

10.4. 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.

10.5. 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.

10.6. 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.

10.7. 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.

10.8. 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.

10.9. 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.

11. Methodology

11.1. 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.
- **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**[7] - including the type of abuse.

11.2. 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.

11.3. The following should be considered in selecting a SAR methodology:

- Is the case complex, involving multiple abuse types and/ or victims?

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

- 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?

11.4. SAR Quality Markers[8] 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.

12. Conducting the Safeguarding Adult Review

12.1. Section 45[9] 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.

12.2. 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).

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

12.4. The appointment of an independent report writer/author will be made via requests through all appropriate networks. The SAR Group is responsible for considering the most appropriate author for each case, and a recommendation will be made to the TSAB Independent Chair.

12.5. SAR authors will be issued with a contract which will include cost for the review and payment schedule.

12.6. Once the SAR Panel members have agreed a final draft of the Overview Report, Executive Summary, and any draft action plan, it will be shared with the SAR Group, where the Author will present the report.

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

12.8. 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

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

[9] Care Act 2014, Section 45

meeting schedule, the Chair of TSAB may call an extraordinary meeting of the TSAB.

13. The report

13.1 The SAR report will be proportionate to the commissioned SAR and will be based upon the specification as set out in the terms of reference.

13.2. Where possible/appropriate the SAR report will include information about the adult subject to the review. The report will be anonymised so that adults can't be identified.

13.3. The report will provide insights into the factors that increase the risk that people will not be effectively safeguarded and/or illuminate conditions that are effective in enabling good safeguarding practice. SAR authors will be expected to consider a systemic approach to the review and go beyond description, instead including deeper analysis about social and organisational conditions that helped or hindered effective, personalised safeguarding.

13.4. All members of the SAR Group/Panel will have had an opportunity to comment on the factual accuracy of the report. Any disputes will be addressed to the Independent Chair who will all review the information.

14. Analysis of SAR

14.1. The SAR Group/Panel will be responsible for quality assuring the report and analysing the approach and methodology including:

- Is there adequate attention to detail and precision in presentation of the facts of the case and professional practice over the time period, to match the commission?
- Has practice in the case been evaluated appropriately, identifying good practice and any shortfalls with reference to up-to-date research and the wider evidence base where this is helpful or necessary?
- Does the assessment of practice in the case reflect the principles of Making Safeguarding Personal and the six core adult safeguarding principles?
- Does the analysis explain why people did what they did in such a way that even incredible actions or inactions are comprehensible in the context of what people were trying to achieve, the challenges and constraints of their work environment, as well as social and cultural aspects of single, multi-agency and multi-professional working?
- Has the analysis of causal factors and efforts to untangle systemic risks been conducted with reference to up-to-date research and wider evidence base on safety science and 'human factors' that underpin a 'systems approach' to learning from practice and incidents?
- Has the analysis clarified whether practice issues were unique to the case(s) and context or emblematic of wider issues and whether the factors that influenced were anomalies or systemic?

- Where required in the commission has the analysis detailed the current relevance of past practice issues and their systemic conditions?
- Where reference is made to practice beyond the case, either at the time of the case or in the present, is it clear where the knowledge about the wider safeguarding system has come from?
- Does the analysis have clear conclusions and show clearly how the conclusions relate to the case(s), as well as why they are relevant to wider safeguarding practice?

15. Involving the adult or their family or representative

15.1. The adult, their family and/or representative should be invited and supported to meaningfully contribute information, experience and perspectives to the SAR.

15.2. Materials will be produced in accessible formats depending on the needs of the family and/or representative.

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

15.4. 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 and whether there are any limitations regarding how individuals can be involved and influence the SAR.

15.5. 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. Clarity and agreement will be sought about how the person and their family and or representative will be represented in the final report.

15.6. Where there are criminal proceedings and family members are witnesses or suspects, a discussion will take place with the police about the precise form and focus of the review, and the implications for when and how family members can be involved.

15.7. The representative with responsibility to liaise with the family will maintain contact with the adult or family throughout the review. 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.

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

15.9. The Care Act 2014 Statutory Guidance comments that it may be helpful to communicate with the person who caused the abuse and neglect. The SAR group will consider if this is appropriate and if so how this could be facilitated.

16. Involving staff

16.1. 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.

16.2. TSAB/SAR author should contact the organisation to seek involvement of their staff member in the review. TSAB will stress the importance of their input, acknowledging their possible fears, clarifying the support that will be available, with the intention of creating a constructive and valuable experience for them.

16.3. TSAB will seek to gather feedback from participants about their involvement in the SAR process.

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

17. Allegations of misconduct

17.1. 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.

17.2. 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.

18. Timescales

18.1. 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.

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

19. Publication

19.1. In the interests of transparency TSAB will publish SARs unless there is reason not to and will be on a case by case basis. Consideration will be given to the public interest, legal advice and confidentiality. This may mean that some sections of the report are redacted.

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

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

19.4. 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.

19.5. Once a date for publication of the SAR has been agreed, a reactive or proactive statement will be drafted by TSAB alongside the Local Authority Communications Team, as appropriate, which considers the timing of publication, prepares press statements in advance and advises interested parties, including Chief Officers and Boards of organisations involved, of imminent publication.

19.6. The SAR should be published as soon as possible after the report has been agreed by the Board.

19.7. The wishes and impact on the person, their family members should be taken into account in plans for publication.

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

20. Embedding learning and evaluation of impact

20.1. It is the responsibility of the individual organisations to progress and monitor their own agency/service recommendations and to make service improvements. The SAR Group will be clear about plans for longer term monitoring of improvement actions and follow up to evaluate impact.

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

20.3. Where the findings or recommendations are not able to be addressed locally this will be taken to national, regional or other forums to consider how to address them.

20.4. 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.

21. Records and retention

21.1. All SAR referrals and subsequent documents will be stored in a secure electronic folder.

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

21.3. 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.

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

Appendix 1 – SAR Form 1

SAR referral form 1 - https://www.thurrocksab.org.uk/what-we-do/safeguarding-adult-reviews/

SAR referral form – **part 2 -To be completed by TSAB**

SAR referral form section 2 template.doc

Appendix 2 – SAR Form 2 - Partner request information form

SAR 2.docx

Appendix 3 – SAR Panel Terms of reference

SAR template TOR.docx

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

Safeguarding Adult Review – Full chronol

Appendix 5 – Information for families

SAR - information for families.docx

Appendix 6 – SAR process map

https://www.thurrocksab.org.uk/wp-content/uploads/2021/09/TSAB-SAR-Policy-Process-Map-1.pdf

Appendix 7 - SAR quality markers

https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-quality-markers-comprehensive-checklist.pdf