**Pan London Safeguarding Adults Review (SAR) Guidelines**

**1. Policy considerations**

1.1 **Mandatory Duty**: Section 44 of the Care Act 2014 mandates Safeguarding Adults Boards (SABs) mustarrange for there to be a Safeguarding Adult 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 these needs) if:

* There is reasonable concern about how the SAB, partner agencies or other persons with relevant functions worked together to safeguard the adult AND
* The adult died as a result of abuse or neglect (or suspected abuse or neglect) OR
* The adult 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.[[1]](#footnote-2)

1.2 **Discretionary Duty**: Section 44(4) permits SABs discretion to arrange for a SAR in any other situations involving an adult in its area with needs for care and support where there are valuable lessons to be learnt with the aim of improving how agencies work together, to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future.

1.3 **Duty to Cooperate**: Section s44(5) requires each member of the SAB to co-operate with the review to assist with identifying the lessons learnt from the case and apply those lessons to future cases. As such, this protocol applies to all SAB partners who have collective responsibility to support local SAB to meet the statutory duties. In recognition that partner agencies and organisations have their own internal governance and learning structures, these guidelines seeks to complement and build on single agency arrangements by adding a multi-agency approach. Working collaboratively, partner agencies can learn lessons from cases where there may have been multi-agency failings and use this learning to improve future joint working. These guidelines can support professionals to decide when to refer a case for consideration of a SAR as well as providing guidance on the SAR process, action planning for implementation of recommendations arising from SARs and securing assurance that partner organisations have implemented learning in line with duties under s44(5) Care Act.

1.4 **Duty to Share Information**: Section 45 Care Act sets out a requirement for any person likely to have information relevant to the exercise of SABs functions (including the completion of a SAR) to supply that information. To aid consistency this will usually be done using agreed formats, examples are given within the appendices. Information collated during the SAR process may be disclosed, if requested, as part of civil or criminal proceedings or to a Coroner. Normally, requests for disclosure of preliminary reports (such as individual partner agencies’ internal management overview reports) will be directed to the relevant agency to respond to as this information is not ‘owned’ by the SAB.

1.5 **Nature and Scope of a Review**: Section 44 permits SABs flexibility to choose a proportionate methodology to complete reviews. These guidelines aim to ensure a consistent and robust approach to the process and practice in undertaking SARs across London. It is designed to support decision-making regarding the selection of the most appropriate learning review method. It also outlines the pathway for commissioning reviews and the governance arrangements. It has been informed by key messages from the [National Analysis of SARs April 2017 – March 2019](https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019), the [National Analysis of SARs April 2019 – March 2023](https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023) and the revised [SAR Quality Markers](https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-quality-markers-comprehensive-checklist.pdf), launched by the Social Care Institute of Excellence (SCIE) in April 2022.

It should also be read in conjunction with the [Care and Support Statutory Guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance) and the London Multi-Agency Adult Safeguarding Policy and Procedures.[[2]](#footnote-3)

As set out within chapter 14.167 of the Care and Support Statutory Guidance, SARs should be based on the following principles:

* A culture of continuous learning and improvement across the organisations that work together to safeguard and promote wellbeing and empowerment of adults, identifying opportunities to draw on what works well and promote good practice.
* Adults at risk and their families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
* The approach to reviews should be fair and proportionate according to the scale and level of complexity of the issues being examined.
* Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
* Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

SAR’s explore how local professionals and agencies worked together to safeguard adults with care and support needs, to review the effectiveness of single and multi-agency procedures and to make recommendations to improve local interagency practice based on the findings of the review. SARs should also build on previous learning and reference the national as well as local context that agencies and practitioners are working within. As such, when setting Terms of Reference, a SAB should reference previous local SARs and explore if similar circumstances have previously been reviewed and findings published on the [National SAR Library](https://nationalnetwork.org.uk/) so this informs the key lines of enquiry and supports the development of evidence based practice. SARs may also identify any issues of national relevance and explore examples of good practice where this is likely to identify lessons that can be applied in future practice. Whenever there is an issue of national importance or commonality across SARs of importance to central government departments and regulatory bodies, the SAB should initiate discussions in line with the [National Escalation Protocol](https://www.local.gov.uk/national-escalation-protocol-issues-safeguarding-adults-reviews-safeguarding-adult-boards). This would support the London SAB network to identify and disseminate regional learning on a thematic level via briefings.

1.6 **Parallel Processes:**  A SAR is not designed to hold any individual or organisation to account, establish how someone died or was harmed, or undertake human resources duties as other processes exist to address those concerns. The SAR process is also not intended to duplicate or replace other agencies’ own internal or statutory review procedures to investigate serious incidents, or their own mechanisms for quality assuring safe practice or for providing practitioners opportunities for reflective practice and de-briefing. There is no requirement that any parallel process (including a safeguarding enquiry undertaken in line with s42 Care Act) is completed before a SAR can commence.

A number of processes can run in parallel to a SAR, including but not limited to:

* Employment and regulatory investigations and disciplinary proceedings, including [referrals to the DBS](https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs?utm_source=Google&utm_medium=Ppc&utm_campaign=Barring&utm_content=Making%20Barring%20Referrals)
* Coroners Inquests and [medical examiners process](https://www.gov.uk/government/collections/death-certification-reform-and-the-introduction-of-medical-examiners)[[3]](#footnote-4)
* Criminal investigations
* [NHS Patient Safety Incident Response Framework (PSIRF)](https://www.england.nhs.uk/patient-safety/incident-response-framework/)
* [Learning Disability Mortality Reviews (LeDeR)](https://leder.nhs.uk/)
* [Child Safeguarding Practice Review](https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel)s
* [Domestic Homicide Review](https://www.gov.uk/government/collections/domestic-homicide-review)s
* [MAPPA Serious Case Reviews](https://mappa.justice.gov.uk/MAPPA/viewCompoundDoc?docid=13159316&partid=13159412&sessionid=&voteid=)
* Mental Health Homicide Reviews or NHS Independent Investigation Reports

Where there are parallel processes, the SAB should address within the SAR Terms of Reference how the process will dovetail with other relevant investigations to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay, and confusion to all parties, including the person, their family and staff. It will be the responsibility of the SAB board manager, in consultation with the SAB Chair, to contact the lead partnership or agency for any parallel processes to ensure effective co-ordination. Particular regard should be had to liaise:

* Where the adult has died, notification to the Coroner and medical examiner
* where there are parallel criminal investigations, liaison with the Police Senior Investigation Officer
* where the subject of a SAR was in the area to receive commissioned treatment, care and support with any relevant commissioning authority (e.g. NHS England, or the local authority or Integrated Care Board (ICB) where the adult was ordinarily resident). In such incidents, that area’s SAB should also be notified and should cooperate across borders with requests for information, as detailed within the [ADASS Safeguarding Adults Policy Network Guidance](http://www.stopadultabuse.org.uk/pdf/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf), but notification should be given to the PSIRF leads.

1.7 **Publication and Retention of Records** As a SAR is intended to be a consultative process, notification of a decision to undertake a SAR will be provided by the SAB to the adult (or their representative if they have died or would have substantial difficulty in taking part in the review), the adult’s family,[[4]](#footnote-5) relevant partner agencies, government departments and regulatory bodies. Where the adult has died, notification will also be sent to Medical Examiners and Coroners.

The findings of any SAR should be reported within the SAB’s annual report. Whilst there is no legal duty to publish the full report, consideration should be given to the wider public benefit of doing so. It may prove necessary to redact information and, to protect the adult and family members, anonymise personal information. Given the purpose of a SAR, draft reports are not intended for publication or wide dissemination as they will be subject to consultation with wider partners, the adult and family to ensure factual accuracy and deliverability. As such, once a final report is ratified by the SAB any draft reports may be destroyed.

Publication of the final report will usually be via the relevant SAB or Local Authority website and a copy of the report will be made available to the [National Network’s SAR Library](https://nationalnetwork.org.uk/search.html). A copy of the Report will be retained by the SAB (or local authority under s43 Care Act) for a minimum of 20 years following the publication of the SAR. This takes into account that the information might be required to protect other adults at risk, need to be accessed by the data subject at a later date or be subject to future investigations, inquiries and litigation.[[5]](#footnote-6)

The decision to destroy or further retain records relating to a SAR will be approved by the SAB and supported by legal advice. If the decision is to proceed with destruction, all agencies who may be retaining duplicate records will be notified in order for them to consider whether to delete or amend their own records. The respective SAB Information Sharing Agreements should be followed in relation to the secure storage and transfer of information relating to the SAR.

1.8 **Complaints and dispute resolution:** Disputes between organisations and professionals involved in a SAR should be resolved with reference to local dispute and escalation SAB procedures.

Any concerns about a SAR and/or the process followed should be raised in the first instance with the SAR Panel Chair and / or SAR subgroup Chair for resolution. The Chair and Vice Chair should ensure they address any potential conflict of interest, drawing on legal advice and from the Chair. Thereafter, if not resolved, matters should be escalated to the SAB Chair and the Local Authority DASS and should be processed in accordance with the Local Authority Social Services and National Health Services Complaint (England) Regulations 2009. The DASS and Chair should have local arrangements to ensure close liaison and how the SAB Chair will be involved in reviewing complaints made about SAB functions. Complaints can be referred to the Local Government and Social Care Ombudsman (LGSCO) if resolution cannot be achieved through the earlier stages outlined. Further information is available in the LGSCO report ‘Casework Guidance Statement: Complaints about Safeguarding Adults Boards’.

**2. Model Procedure**

2.1 **Identification and Referral for a SAR**: Any agency, professional, or individual may refer cases to the SAB. Referrals are to be made using the Consideration Request Form (see **Appendix A**) which is to be sent to the SAB Board manager in the area where the abuse or neglect occurred. Referrers will receive an email from the SAB Support Team to confirm receipt of the SAR referral.

The Chair of the SAB, the Director of Adult Social Services (DASS) and Chair of the SAB SAR subgroup will be notified in the first instance and, if they are satisfied it is reasonable (given the mandatory criteria and discretionary powers) to give full consideration of the request, the SAB board manager will write to relevant agencies to require they complete an initial summary of their involvement (**Appendix B**). These should be completed within 10 working days.

2.2 **Initiating a Safeguarding Adults Review**: The SAB SAR subgroup should be notified of the referral as soon as is practicably possible and arrangements made for the referral to be considered (an extraordinary meeting may need to be convened). The decision about whether to undertake a SAR, and the nature of the SAR that is required, will need to take into account factors related to the case and the local context. The primary consideration is whether there is a mandatory/discretionary obligation to undertake a SAR, using the criteria in s44 Care Act. The rationale for any recommendations should be transparent and reached in a timely fashion. Any delays in decision-making should be referenced and explained. There should be opportunities for the adult or their representative, family and relevant partners to contribute their views and relevant information. The recommendations should usually be ratified by the SAB Chair, any Executive committee and shared with SAB members.[[6]](#footnote-7)

2.3 **Determining the Methodology:** The statutory duty enables wide discretion in the format and methodology used to review a case. Learning from the two national analysis of SARs[[7]](#footnote-8) advocates that greater attention is needed to protected characteristics within safeguarding practice, as such particular care should be taken to ascertain information/data relevant to protected characteristics and SABs should actively consider how equality, diversity and inclusion issues will be addressed through the methodology and terms of reference.

In determining the methodology and key lines of enquiry within a review, the SAR panel should set out within the Terms of Reference prior learning and the existing evidential evidence base for good safeguarding practice. This should reference the impact that academic research, case law and both national and local SARs have had practice improvement.

It will be for the SAB (or relevant sub-group with input from the SAB Chair) to determine the methodology according to a range of factors so that the process is proportionate and ‘*the focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or have been seriously abused or neglected*’. In line with findings from the national SAR analysis, the focus of the SAR should be on why and relate this to national context where relevant. This may include a ‘rapid review’ as developed by SCiE. Best practice suggests that a range of different methodologies should be available. The SAR subgroup or Panel will need to consider the various options and decide which approach is likely to provide the most learning proportionate to the situation. All review methodologies outlined have some degree of flexibility. **Appendix C** includes more information about different methodologies that may be used. Key to this is agreeing the SAR Terms of Reference (TORs) which could be agreed as draft and subsequently confirmed by the SAR subgroup or revised as appropriate with the SAR Panel and Chair.

2.4 **SAR Process**: A SAR panel should be appointed to oversee the process, made up of senior representatives from agencies involved in the SAR and, if appropriate, also drawn from wider interested partners. A person who is independent of the case should be appointed as Chair. Consideration should be given to the appointment of an independent reviewer with suitable experience and expertise in safeguarding and quality assurance. The independent reviewer will need to provide assurance that they understand requirements of the General Data Protection Regulations and how it impacts on the retention of any information they will store in relation to the review. The reviewer should be able to produce a SAR report which fulfils the terms of reference for the review and is compliant with the SAR SCIE Quality Markers.

2.5 **Appointing an Independent Reviewer:** Each SAB should have an agreed local formal procurement process in place for appointing independent reviewers. Where the SAB is unable to directly contract with third parties, the Terms of Reference should address which partner agency will be responsible for commissioning the reviewer. The formal procurement process and contract with the independent reviewer should clarify, among other issues, access to legal advice (if required), requirements for the reviewer to have suitable levels of insurance, detail expectations regarding compliance with data protection requirements and make reference to the SCIE SAR quality markers. Any terms of reference or contract of engagement could also require a SAR reviewer to report information to the SAB Chair where it appears the facts could give rise to liability issues, namely:

* civil liability, including negligence by a public body;
* criminal liability;
* regulatory enforcement issues;
* employment law issues in respect of a particular person or organisation.

The contract should also make clear that the SAR panel will be responsible for fact checking and quality assuring the final report in line with the SAR quality markers and with regards to the specific Terms of Reference. Family members should also be given an opportunity to meet with the Independent Reviewer to fact check the report and provide comments. Professionals involved in the case should report any factual inaccuracies or concerns to their relevant panel representative or, if their organisation is not represented on the panel, to the Independent Reviewer and Panel Chair.

The contract should also set out how the independent reviewer would be expected to be involved in dispute resolution or complaint processes, particularly where these give rise to concerns regarding alleged breaches of obligations regarding personal information, negligent misstatements and defamation.

The contract should also clarify that whilst reviewers can use published materials freely, they should seek agreement from the SAB before disseminating information from unpublished reports (either within research papers or for any other means).

2.6 **Timescales for a SAR:** There is an expectation in the Care Act 2014 that SARs are completed within 6 months. Below is a proposed project timeline for a SAR, but this is intended as a guide and will need to be adjusted to ensure cases are considered in a proportionate way to ensure necessary learning is achieved and equally allow sufficient time for family engagement in key parts of the process.

2.7 **Involving the Adult and Family Members**: Whilst consent from the adult(s) and/or their family is not required for the review to go ahead, all adult(s) and family members or representatives involved in a SAR should be given clear information about the SAR process so that they understand the purpose of a review and the specific scope that the review will consider. Adults and/or their family/representatives should be provided with a copy of the SAR guidelines for family members and carers (Appendix D) and invited to be involved in the review.

The SAR Terms of Reference should specify any corresponding duties such as the police approach, in line with the Victim’s Code, to provide family liaison. This may prove a useful starting point to avoid duplication or additional distress to families. Consideration should be given as to whether the adult and/or their family may benefit from the support of an advocate. In situations in which the adult(s) would have “substantial difficulty in participating themselves” and there is no other appropriate person to assist them, the local authority has a duty under the Care Act 2014 to involve an independent advocate. Reasonable support and adjustments should also be made as required to support the adult and/or their family/carers to participate in the SAR. This may include easy read/ large print / translated documents, access to an interpreter, support from a chosen representative, longer meeting times, pre and post meeting briefings.

2.8 **Responsibilities to, and Involvement of Staff:** The death or serious injury of the individual(s) will have an impact on staff and indeed may be felt at a wider level within the organisation. As soon as a SAR has been agreed, any practitioners directly involved in the care and support of the individual(s) subject to a SAR should be notified of the decision to undertake the review by their agency. The purpose, process and circumstances of the review should be fully explained, and practitioners should be supported to take part by their agency. This should include support in relation to their health and wellbeing to minimise risks their involvement causes distress.

All relevant practitioners should be given an opportunity to share their experiences and opinions on the case as appropriate to the methodology used. This should include their views about what they felt could have made a difference to the individual(s) and/or family. All agencies must encourage, and support practitioners involved in a SAR to be open and transparent in sharing their views, without fear of blame or reprisal, so that learning can take place.

2.9 **Report and Recommendations**: The final SAR report “*should be written in plain and easy to understand language…. and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence*”. The final report should contain:

* A sound analysis of what happened.
* Any errors or problematic practice and/or what could have been done differently.
* Why those errors or problematic practice occurred and/or why things were not done differently.
* Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become system findings.

The SAR Panel normally reviews the draft report to ensure a sufficient level of analysis, scrutiny and evaluation of evidence, before this is presented to the adult or their family, any relevant partners or organisations and the SAB. The final report will then be presented to the SAB, usually by the Independent Reviewer for final agreement.

2.10 **Publication and Communication**: Any media and communication issues will usually be coordinated by the Council’s Communications Team. This will be done in collaboration with Communications Teams of other relevant agencies involved, alongside agreed representatives of the Board. The SAB Chair will release a press statement where appropriate.

2.11 **Implementation and Evaluation**: The real value of completion of a SAR is to ensure that the relevant learning has led to changes within organisational systems and in practice, so as to ensure safeguarding is improved and to prevent the issues in question happening again. The SAR subgroup will consider the recommendations from the report and agree an action plan. The development of an action plan may be delegated to a task and finish group or another SAB sub-group with representation from relevant agencies involved who will report progress back to the SAR or relevant subgroup.

The multi-agency action plan will include:

* The actions that are needed.
* Which agency and/or lead professional is responsible for specific actions.
* Timescales for completion of actions.
* The intended outcomes – what will change as a result?
* Mechanisms for monitoring and reviewing intended improvements.
* The processes for dissemination of the SAR report and/or its key findings.

The SAB will have a local process to monitor progress on all recommendations and may request periodic progress update reports from partner agencies and relevant organisations (in line with statutory duties under s44(5) and s45 of the Care Act), until the time all actions completed. Reports on the implementation of action plans across the partnership are usually presented to Board meetings and must be published within the SAB’s annual report[[8]](#footnote-9).

Individual Board members are responsible for ensuring that all actions for which their organisation is responsible are completed, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. Wherever possible agencies should make every effort to capture learning points and take internal improvement action while the SAR is in process, rather than waiting for the SAR report and action plan.

Sharing and embedding learning from SARs is a priority of the SAB. It is also reflected in the National Quality Board’s position statement for Integrated Care Systems (ICSs)[[9]](#footnote-10). SARs provide a rich source of learning to support continuous professional development as well as a significant evidence base which can help to develop a shared understanding of complex and often challenging areas of adult safeguarding practice. The SAB will usually produce learning briefings for all SARs to raise awareness of the key learning and to promote reflective discussions amongst front-line practitioners and managers within partner agencies. The SAB will also cascade learning through a variety of other mechanisms including multi-agency learning events of workshops and bitesize learning materials, such as podcasts and webinars.

SAB members who are responsible for training commissioning and delivery within their organisations should lead on ensuring that learning from SARs is directly reflected within the content of their safeguarding training programmes. Care should be taken to ensure training materials focus on the learning from reviews and are not overtly critical or partners or individual practitioners as this can undermine partnerships and the overarching purpose of this process.

The SAB will ensure that there is a shared approach across the safeguarding partnerships, including the Local Safeguarding Children Partnership and the Safer Communities Partnership to sharing learning emerging from reviews.

2.12  **Useful Resources**: The following resources provide additional information in relation to SARs and adult safeguarding:

[National Analysis of Safeguarding Adults Reviews](https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019)

[SCIE SAR Quality Markers](https://www.scie.org.uk/files/safeguarding/adults/reviews/quality-markers/scie-sar-quality-markers-comprehensive-checklist.pdf)

[SCIE Guidance on SARs](https://www.scie.org.uk/safeguarding/adults/reviews/care-act)

[Sharing Information](https://www.scie.org.uk/safeguarding/adults/practice/sharing-information)

[User involvement in Safeguarding](https://www.scie.org.uk/publications/reports/report47/)

Appendix : SAR referral form

Safeguarding Adults Review (SAR) Referral Form

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Safeguarding Adults Review subgroup of the Safeguarding Adults Board (SAB) considers every SAR referral in accordance with the the London Multi-Agency Adult Safeguarding Policy and Procedures.

Before submitting your referral, please consult the SAR guidelines, as well as the SAR Referrals Briefing Note.

If you feel that the SAR criteria are met and need to submit a referral, we ask that you discuss this initially with a senior manager or safeguarding lead within your organisation before submitting a referral. The referral should also be authorised by a senior manager within your organisation. You can also contact the SAB Business Manager for consultation on referrals via the email address listed below. Please complete the referral form with as much information as possible.

The completed referral should be sent via secure email to: [insert relevant email address]

SECTION 1: REFERRAL INFORMATION

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DETAILS OF ADULT | | | | | | | | | |
| Full name of adult: | | |  | | | | | | |
| Date of birth: | | |  | | | | | | |
| Address: | | |  | | | | | | |
| Ethnicity: | | |  | | | | | | |
| Disability / care and support needs: | | |  | | | | | | |
| Sex / gender: | | |  | | | | | | |
| Religion / belief: | | |  | | | | | | |
| Civil / marital status: | | |  | | | | | | |
| Borough of ordinary residence: | | |  | | | | | | |
| Case identifier e.g. Mosaic/RIO/Datex /CAD/ NHS number (if relevant) | | |  | | | | | | |
| Date and place of serious incident or death: | | |  | | | | | | |
| GP details: | | |  | | | | | | |
| Family / next of kin / representative details (including name, address and contact details): | | |  | | | | | | |
| Are family or next of kin aware of the SAR referral? If no, please give reason why: | | |  | | | | | | |
| If yes, what are their views of the concern? | | |  | | | | | | |
| How would they like to be contacted? | | |  | | | | | | |
| DETAILS OF INDIVIDUAL / ORGANISATION MAKING SAR REFERRAL | | | | | | | | | |
| Referral date: | | |  | | | | | | |
| Name: | | |  | | | | | | |
| Role / position: | | |  | | | | | | |
| Organisation: | | |  | | | | | | |
| Address: | | |  | | | | | | |
| Email: | | |  | | | | | | |
| Contact number: | | |  | | | | | | |
| Authorising manager: | | |  | | | | | | |
| Role / position: | | |  | | | | | | |
| Contact number: | | |  | | | | | | |
| Email: | | |  | | | | | | |
| DETAILS OF THE CASE | | | | | | | | | |
| Brief summary of concerns which have triggered this referral:  *NB: Please use plain language that can be understood by those with no prior knowledge of your agency and provide the meaning of any acronyms you use. Please do not copy and paste extensive information from your agency’s records.* | | | | | | | | | |
| Please identify the type(s) of abuse relating to this case (more than one may apply):  Physical Abuse  Neglect / Acts of Omission  Self-Neglect  Financial Abuse  Domestic Abuse  Psychological Abuse  Sexual Abuse  Modern Slavery  Organisational/Institutional Abuse  Discriminatory Abuse | | | | | | | | | |
| EXPLAIN HOW THE CASE MEETS THE CRITERIA FOR A SAR | | | | | | | | | |
| Please refer to the criteria for a SAR as set out within the SAR guidelines and explain in detail how you feel this case meets the criteria: | | | | | | | | | |
| What are the multi-agency lessons to be learnt: | | | | | | | | | |
| Please indicate any emerging themes:  Complex needs and multiple disadvantage  Homelessness  Mental capacity  Non-engagement  Pressure ulcers  Suicide  Social isolation  Transfer of care  Trauma | | | | | | | | | |
| AGENCIES INVOLVED: | | | | | | | | | |
| Agency | | Key contact person | | Contact details | | | Agency informed of SAR referral? | | |
|  | |  | |  | | |  | | |
|  | |  | |  | | |  | | |
|  | |  | |  | | |  | | |
|  | |  | |  | | |  | | |
|  | |  | |  | | |  | | |
|  | |  | |  | | |  | | |
| PARALLEL PROCESSES | | | | | | | | | |
| Have any other processes commenced which are looking into the circumstances of this case and/or you are aware of any that are likely to be instigated? | | | | | | | | | |
| Process | | | | | Commenced | | | Planned | |
| Yes | No | | Yes | No |
| Section 42 Safeguarding Adults Enquiry | | | | |  |  | |  |  |
| Criminal Investigation | | | | |  |  | |  |  |
| Coroner’s Inquest | | | | |  |  | |  |  |
| Domestic Homicide Review (DHR) | | | | |  |  | |  |  |
| Mental Health Homicide Review (MHHR) | | | | |  |  | |  |  |
| Child Safeguarding Practice Review (CSPR) | | | | |  |  | |  |  |
| NHS Review under PSIRF | | | | |  |  | |  |  |
| Learning Disabilities Mortality LeDeR Review | | | | |  |  | |  |  |
| Agency Complaints Process | | | | |  |  | |  |  |
| Other (please state) | | | | |  |  | |  |  |
| Please provide additional details of any parallel processes below, including lead contact, current status of process and if completed outcomes: | | | | | | | | | |
| SENIOR MANAGER SUBMISSION AND AUTHORISATION OF REFERRAL | | | | | | | | | |
| Completed by: |  | | | | | | | | |
| Signed: |  | | | | | | | | |
| Date: |  | | | | | | | | |

|  |
| --- |
| Please provide any supplementary documentation which could support your referral, please tick as appropriate: |
| Section 42 report  Serious Incident Review  Root Causes Analysis  Provider internal investigation report  Domestic Homicide Review  Child Safeguarding Practice Review  Learning Disabilities Mortality Review (LeDeR)  Chronology |

SAB USE ONLY FROM HERE ONWARDS

SECTION 2: TRAIGE BY SAB CHAIR & DASS

|  |  |  |
| --- | --- | --- |
| TRIAGE INFORMATION FROM THE REFERRER | | |
| Date referral received: | |  |
| Date contact made with the referrer: | |  |
| Summary of discussion with the referrer: | |  |
| SAR NOTIFICATION LETTERS | | |
| Date notification letters sent to SAB Chair & DASS: | |  |
| TRIAGE INFORMATION FROM SUPPORTING AGENCIES (IF APPLICABLE) | | |
| Name: | |  |
| Role / position: | |  |
| Organisation: | |  |
| Contact details: | |  |
| Date of discussion, if applicable: | |  |
| Summary of discussion and agency view: | |  |
| LINKS OR SIMILARITIES WITH LOCAL OR NATIONAL REVIEWS | | |
|  | | |
| TRIAGE COMPLETION BY SAB Chair & DASS | | |
| Decision of SAB Chair & DASS (indicate if any disagreement) and reasons for decision: |  | |
| Date: |  | |
| Feedback provided to referrer? |  | |

SECTION 3: SAR SUBGROUP CONSIDERATION AND RECOMMENDATION

|  |  |
| --- | --- |
| PRESENTATION TO THE SAR or Case Review subgroup | |
| Name / role / agency: |  |
| Date: |  |
| Summary of discussion and agreed actions (usually taken from subgroup minutes): |  |
| SUBGROUP RECOMMENDATION | |
| Date: |  |
| Recommendation and rationale for decision including:  Confirmation as to whether a SAR is recommended and mandatory / discretionary  Feedback to referrer  Proposed methodology  Adult / family involvement |  |

SECTION 4: SAB DECISION

|  |  |
| --- | --- |
| Date of consideration: |  |
| Comments: |  |
| Signed: |  |

1. PG14.163 Care and Support Guidance, DHSC [↑](#footnote-ref-2)
2. Section 2.9 of the Safeguarding Policy and Procedures specifically covers SARs. [↑](#footnote-ref-3)
3. More details of the medical examiner process is also available at: <https://www.england.nhs.uk/patient-safety/patient-safety-insight/national-medical-examiner-system/> [↑](#footnote-ref-4)
4. For the avoidance of doubt this is interpreted broadly to reflect duties protected under article 8 Human Rights Act 1998. [↑](#footnote-ref-5)
5. In the absence of legislation or regulation, the designated retention period has been informed by the [Health and Social Care Records Retention Schedule](https://transform.england.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice-2021/#appendix-ii-retention-schedule) which states that “The retention periods listed in this retention schedule must always be considered the minimum period. With justification, a retention period can be extended for the majority of cases, up to 20 years” AND the R v Northumberland County Council and the Information Commissioner (23 July 2015) judgement which provided assurance that it is legitimate to vary common practice and guidance where there is a well-reasoned case for doing so. [↑](#footnote-ref-6)
6. Where there is a locally agreed scheme for delegating decision making that should be applied. [↑](#footnote-ref-7)
7. Available at: <https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023>

   [↑](#footnote-ref-8)
8. Sch 2, s4(1)(d)-(g) Care Act 2014 [↑](#footnote-ref-9)
9. The [National Guidance on System Quality Groups](https://www.england.nhs.uk/wp-content/uploads/2022/01/B0894-nqb-guidance-on-system-quality-groups.pdf) sets out the importance of ensuring quality is the organising principle of ICSs and that this involves sharing learning and celebrating best practice. [↑](#footnote-ref-10)