Doncaster
Safeguarding Adults Board

Safeguarding Adults Review Policy and Toolkit

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Glossary of Terms

CQC – Care Quality Commission

DSAB – Doncaster Safeguarding Adults Board

IMR – Individual Management Review

LLR – Lessons Learned Review

LSAB – Local Safeguarding Adults Board

PREPARE GROUP – Formal sub group of the Doncaster Safeguarding Adults Board

RLSG – Review and Learning Sub Group

SAR – Safeguarding Adults Review

SMART – Specific, Measurable, Achievable, Realistic, Timely

TOR – Terms of reference

Amendments

The amendments since V2 are in relation to the Board restructure, introduction of a new Review and Learning sub group and subsequent governance arrangements for receiving and responding to SAR requests under the Care Act 2014.

Acknowledgments

The following document has been reviewed and used to develop this policy;
Leeds Safeguarding Adults Board Safeguarding Adults Review Policy and Toolkit Policy

1 Introduction

1.1 This policy has been revised to reflect the statutory requirements of Safeguarding Adults Board in relation to Safeguarding Adults Reviews (SARs) as outlined within the Care Act 2014.

1.2 The core duties of a Safeguarding Adults Board are set out in chapter 14 of the Care Act Guidance, issued under s78 Care Act 2014. One of the core duties is that Safeguarding Adults Boards **must** arrange and undertake Safeguarding Adults Reviews when the criterion is met in accordance with s44 Care Act.

1.3 Doncaster Safeguarding Adults Board values itself for being open and transparent, and proactive in learning from Safeguarding Adults Reviews to ensure that the Partnership develops and uses a positive reflective practice approach to inform the development and assurance of safeguarding adults work in Doncaster.

1.4 Safeguarding Adults Reviews are essential in helping the Board prevent abuse and neglect of adults at risk and learn from cases and situations that challenge us as a multi-agency partnership.

1.5 The Care Act 2014 outlines the following principles to be applied by SABs and their partner organisations when undertaking Safeguarding Adults Reviews:

- there should be a culture of continuous learning and improvement across the organisation 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 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; and
- families should be invited to contribute to reviews and should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

1.6 The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. 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 been seriously abused or neglected.

2 Purpose

2.1 This Policy and Toolkit is designed to explicitly set out the roles and responsibilities within Safeguarding Adults Reviews to clarify the governance arrangements relating to such reviews.

2.2 The purpose of having a SAR is:

- To seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death.

- To identify lessons that can be learned from the case and applying those lessons to prevent similar harm occurring again

2.3 SARs are **not** enquiries into how an adult at risk died or who is to blame; nor is it to hold any individual or organisation to account, other processes exist for that e.g. Criminal proceedings, disciplinary procedures, employment law, professional regulation such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

2.4 Where the Board consider the request not to meet the criteria for a SAR but still deem there are lesson to be learned across the multi-agency partnership a Lessons Learned Review (LLR) may be recommended and this policy can be used to support the process.

3. Links to other reviews

3.1 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both child SCR and a Domestic Homicide Review (DHR). Where such reviews may be relevant to SAR (e.g. Because they concern the same perpetrator), consideration should be given to how SARs, DHRs and SCRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example considering whether some aspects can be commissioned jointly to reduce duplication of work for organisations involved.

3.2 In setting up a SAR the DSAB should also consider how the process can dovetail with any other relevant investigations that are running in parallel, such as a child SCR or DHR, a criminal investigation or an inquest.

3.3 It may be helpful when running a SAR and DHR or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential of duplication for families and staff. Any SAR will need to take account off a coroner's inquiry, and or any criminal investigation related to the case including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

3.4 In all cases where children are identified within a Safeguarding Adults Review the Doncaster Safeguarding Children Board should be notified.

4 Criteria for Safeguarding Adults Review

4.1 The Doncaster Safeguarding Adults Board (DSAB) has the lead responsibility for agreeing and conducting a SAR.

4.2 A SAR should be considered 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.

or

An adult in its area has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced **serious** abuse or neglect. E.g. 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 of neglect.

4.3 The DSAB are also free to consider conducting a SAR into any incident(s) or case(s) involving adults at risk. E.g. where it is believed to be in the public interest to conduct such a review.

4.4 Any agency or professional body, also councillors, MPs and the Coroner may refer such a case to the DSAB seeking a Safeguarding Adults Review to establish if there are important lessons for inter-agency work to be learnt from a case.

4.5 The Secretary of State also has authority under the Local Authority Social Services Act 1970 to cause an enquiry to be held where she/he considers it advisable.

4.6 There will also be situations where the Review and Learning Sub Group will recommend that the case does not benefit from any form of review and a recommendation with clear rationale will be presented to the DSAB for them to make an informed decision.

5. The Coroner

5.1 Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations;

- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home); or,
- Deaths that fall outside the requirement to hold an inquest but follow-up enquiries / actions are identified by the Coroner or his or her officers

5.2 In addition Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides Coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. All reports (formerly known as Rule 43 reports) and responses must be sent to the Chief Coroner. In most cases the Chief Coroner will publish the reports and responses on this website.

5.3 If HM Coroner contacts the DSAB about any of these situations, the Review and Learning Sub Group will give careful consideration to conducting a SAR.

6. Requesting a Safeguarding Adults Review /Lessons Learned Review

6.1 Any agency or professional may make a request for a SAR following discussion with their manager and their agency's safeguarding lead. Requests must be in writing using the SAR Request Form (see Appendix 1). The form requires referrers to explain why this case requires review, outlining why the criteria has been met with a focus on the potential learning for DSAB.

6.2 The request form is held on the DSAB website at www.doncaster.gov.uk/safeguardingadults . The request form should be sent via secure email to dsab@doncaster.gcsx.gov.uk for the attention of the Safeguarding Adults Board Manager. Where the referrer does not have a secure email address, they should telephone the Doncaster Safeguarding Adults Board Support Unit on (01302 736230/735065) and discuss how best to send the form.

6.3 This will be acknowledged by the Safeguarding Adults Board Manager **within 2 working days** and contact will be made with the referrer to discuss the request and to identify who should present to the Review and Learning Sub Group.

7. Decision to Conduct a Safeguarding Adults Review and Methodology

7.1 The Review and Learning Sub Group will consider the request **within 28 days** of receipt of the SAR Request Form. Where its next scheduled meeting is not within 28 days an ad-hoc meeting or virtual meeting should be held to consider the request.

7.2 The Review and Learning Group will form a view using the criteria set out in section 4.2, on whether;

a) A Safeguarding Adults Review is required,
b) A Lessons Learned Review is recommended

c) A single agency internal review is recommended,
d) No review is required, or
e) Scoping / further information is required

7.4 The Review and Learning Group will then make a recommendation to the Prepare Group and seek a decision from the DSAB Independent Chair. This decision will be made **within 14 days**.

7.5 Where a decision is made to undertake a SAR, the PREPARE Group will delegate responsibility to the Review and Learning Sub Group who will coordinate the following;

- determining which agencies should participate in the SAR/LLR (referred to as the SAR Group)
- identifying an appropriate methodology (refer to Appendix 2 - SAR Methodologies)
- identifying the desired output i.e. SAR Report
- timescales for completion
- identifying any urgent action required

7.6 The DSAB should aim for completion of a SAR within a reasonable period of time and in any event **within 6 months of Board approval** to initiate it, unless there are good reasons for a longer period being required; E.g. because of potential prejudice to related court proceedings.

7.7 The Safeguarding Adults Board Manager is responsible for ensuring the referrer and the Review and Learning Sub Group are kept informed of the DSAB Independent Chairs decision.

7.7 Once a decision has been made to instigate a SAR, the CQC and any other appropriate agencies, organisations and bodies (i.e. Coroner) will be notified of the decision.

For a procedural overview of the SAR Decision Flowchart refer to Appendix 3.

8. Roles and Responsibilities

8.1 <u>Independent Chair of the DSAB</u>
The Independent Chair of the DSAB is responsible for making a decision in response to the Review and Learning Sub Group's recommendations for a SAR, the appointment of an independent author with the right level of seniority and objectivity and its associated methodology etc. The Independent Chair of the DSAB is responsible for ensuring the Board receives regular updates in respect of progress of SARs or other such reviews.

8.2 <u>Doncaster Safeguarding Adults Board</u>

"*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." Care Act Statutory Guidance 2015

It will be the responsibility of the DSAB to appoint the Independent Author (refer to Appendix 5) and to ensure he/she has the required level of objectivity to undertake the SAR in the interests of openness and transparency (this may be delegated to the Review and Learning Sub Group where appropriate).

Constituents of the DSAB will nominate appropriately experienced and senior staff to participate in SARs in consultation with their agency's senior responsible manager.

Constituents of the DSAB will consult regularly with those staff from their agency who are participating in Safeguarding Adults Reviews to ensure they are informed but also can provide support and guidance. DSAB constituents should recognise that both these roles are exceptionally time-consuming and challenging and have a responsibility to ensure that their organisation provides these people with protected time and appropriate support to enable them to perform effectively in these roles.

DSAB constituents are responsible for ensuring their organisation's actions within SAR multi-agency action plans are achieved.

8.3 Review and Learning Sub Group

The Review and Learning Sub Group is responsible for recommending to the Independent Chair of the DSAB whether a request for a SAR meets the criteria. It is solely the Group's role to make this recommendation. This recommendation will be made on a SAR Request Form (refer to Appendix 1) and will clearly state the reasons for this recommendation.

As part of the request, the Review and Learning Sub Group will consider and recommend who the final SAR report should be shared with and who the main stakeholders are likely to be. This will enable consideration of whether the full report or the executive summary report will be made public and a provisional media strategy to be developed. **An executive summary must be written and published in every case.**

The Independent Chair of the DSAB will consider the recommendation of the Review and Learning Sub Group and decide whether or not to conduct a SAR or other appropriate review.

Where a case is considered to meet the criteria, the Review and Learning Sub Group will make recommendations about the overall approach of a SAR or other such reviews.

The Review and Learning Sub Group will recommend to the Independent Chair of the DSAB, where relevant, how the Adult at Risk, Person(s) and / or Organisation(s) Responsible and / or family members should be involved. Where considered appropriate the SAR Independent Author will meet them at the start of the SAR to hear their views, explain the process and where appropriate, enable their perspective to be fed into the SAR.

Where children are identified within a Safeguarding Adults Review it is the role of the Review and Learning Sub Group to notify the DSCB.

The Review and Learning Sub Group is responsible for performance managing the SAR process and reporting progress to the Board through the Prepare Group at each of its meetings.

The Quality and Performance Sub Group is responsible for monitoring and recommending to the DSAB completion of SAR / LLR action plans.

8.4 Independent Author

The Independent Author will work with members of the Review and Learning Sub Group to define the Terms of Reference (refer to Appendix 4), undertake the SAR and produce the Report. This Report will have recommendations that are agreed by the Review and Learning Sub Group. These will be SMART and will provide the DSAB with positive learning that will enable it to improve services and safeguard adults at risk across Doncaster.

It is the responsibility of the Independent Author to communicate directly with Adults(s) at Risk, Person(s) or Organisation(s), family members or significant others throughout the review process.

8.5 Safeguarding Adults Review Group

A SAR Group will be formed to contribute to the review. Members of the SARG will be nominated by the Review and Learning Sub Group and Board constituents in relation to issues identified within the SAR and the agencies involved.

They will be people with the ability and seniority to effect real change in their organisation and to influence others in the review to effect change across the Partnership.

Members of the SARG will feedback to their agency's DSAB Board constituent on progress and key issues emerging from the review.

The SAR Group will;

- decide whether the agencies concerned should secure their files.
- draft a Terms of Reference for each SAR (see Appendix 4)
- apply the methodology agreed by the DSAB
- produce the required output within the required timescale as agreed by the DSAB i.e. SAR Report
- The SARG will notify the CQC of the outcomes and action plans arising from SARs.

The Care Act Statutory Guidance identifies the following expectations for those undertaking SARs;

- 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 and ability to manage qualitative data;
- safeguarding knowledge;
- inclined to promote an open, reflective learning culture.

8.6 Safeguarding Adults Review Group

The Safeguarding Adults Review Group supported by the Safeguarding Adults Board Support Unit is responsible for supporting the coordination and administration of the Safeguarding Adults Review to ensure it is submitted to the Review and Learning Group, Prepare Group and Board in line with timescales.

Notifying agencies of the SAR and requesting that files be sealed where appropriate. Also notifying the adult at risk, family and friends as appropriate and keeping people updated on the progress of the SAR.

Supporting the Independent Author by requesting, gathering, collating and merging information relating to chronologies in preparation for meetings and learning workshops.

Also facilitating quality assurance of the final report and action plans to ensure they are fit for purpose and SMART.

9. Role of Legal Advisors

9.1 In some cases legal advice may be required. The main focus of legal advice provided to DSAB is to ensure that the review fulfils its purpose by being appropriately disseminated without exposing DSAB to unnecessary legal challenge. Where any in house legal services has had substantial involvement in the case before the event which triggers the SAR, there may be a need to examine that involvement in the Review. This would normally be done as part of an IMR.

10. Disclosure of Information

10.1 In line with the principles set out in section 1 the DSAB will consider carefully whether the full SAR report will be published and shared with practitioners and the public. **An executive summary must be written and published in every case.**

10.2 The SAR Group will, as part of the scoping of the SAR, seek a decision from the DSAB on the issue of disclosure of information (see Appendix 8 for further information on disclosure which should be considered).

10.3 The SAR Group will need to consider what information gathered in the completion of a SAR will be disclosed and to whom. The focus of those discussions should be to agree what the public interest issues are and how best to facilitate public accountability. In addition the Board will need to consider how

lessons about how agencies will work together to safeguard adults are best disseminated.

11. Notification and Involvement (Agencies, Family, Victims, Alleged Perpetrators)

11.1 Agency Notification

Once a SAR has been commissioned, the Safeguarding Adults Board Manager will send a copy of the SAR Request Form / and Agency Notification Letter (refer to Appendix 6) to all core members involved in the SAR and to any other agencies where there is any indication that they may have been involved in the case. This requires agencies to seal their files and to confirm if they have had any contact with the adult or family and briefly outline their knowledge of the case.

The Agency Notification Letter should be copied to Chief Officers of the Board and to Chief Officers of other organisations where there is knowledge to indicate that they may have had involvement. This includes agencies out of district. It is therefore vital that as soon as core constituents become aware that other agencies including those out of district have had involvement with the adult that the Safeguarding Adults Board Manager is made aware.

11.2 Notifying and Involving the Adult at Risk, Families, Friends

Each case is unique and it is therefore important that careful consideration is given to the best way of notifying and involving families. Involving the adult, family and friends can range from formal notification only, to inviting them to share their views with the Independent Author in writing or through interview. These questions will form part of the discussions when the PREPARE Group is requesting a decision from the DSAB and will be written into the Terms of Reference for the particular SAR.

Early discussion needs to take place with the adult at risk, family / friends to agree how they wish to be involved. The Care Act 2014 requires where appropriate, for an independent advocate to represent and support throughout a Safeguarding Adult Review (SAR), this should be considered and offered to the adult at risk to enable involvement. The adult who is the subject of any SAR need not have been in receipt of care and support services for the DSAB to arrange a review in relation to them.

Normally the adult at risk / family / friend (this is usually family members who play a significant role in the adult's life), should be notified that the SAR is taking place. This is best done in person and followed up by a letter (see Appendix 9) together with an explanatory leaflet (see Appendix 10) either directly to the family members or via their solicitor(s), as seems most appropriate given the particular circumstances. The timing of such notifications is crucial particularly where there are ongoing police investigations. Under these circumstances, the decision about when to notify needs to be considered by the Board, with the police representative present. Liaison with the adult at risk, family and friends is the responsibility of the Independent Author.

The Executive Summary can be a useful tool where mental capacity issues have been identified for the adult at risk. It may be appropriate, for this to be done in person, rather than by letter.

11.3 Notifying Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and Significant Others

It is also vitally important to consider the Person(s) or Organisation(s) Alleged to Have Caused Harm as they can play a valuable role in the SAR process. The DSAB values the importance of their views and also recognises that the process can be difficult. Each case shall be considered on a case by case basis by the SAR Group and Independent Author to ensure a holistic view has been represented to gain the maximum benefits from the SAR process.

As such, the Independent Author will offer to meet with those individuals, as agreed appropriate as soon as the decision has been made to proceed with a SAR in order to hear their views and explain the process, highlighting the purpose of the review and signposting them to other routes if they wish to make a complaint.

The Safeguarding Adults Board Manager will keep all relevant individuals regularly informed of progress through the review.

12. Media

12.1 This will be determined on an individual case basis, with consideration given to the potential for the case to have a significant impact on public confidence regionally. Where necessary a meeting should be called involving the relevant agencies and their respective Communications Officer and an agreed statement drafted prior to the publication of the Summary. Consideration should be given to Board taking the lead, with a statement agreed by the various agencies and where appropriate, those individual agencies preparing their own statements. Consideration should also be given to a press briefing/conference being necessary or helpful in the individual circumstances of each case.

13. Final Reports

13.1 The final report will be written by the Independent Author and its content agreed by the SAR Group and Review and Learning Sub Group. The Safeguarding Adults Board Manager will additionally quality assure the final report and provide comments directly to the Independent Author and/or through the SAR Group.

13.2 The SAR Report should:

- Provide sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

13.3 The DSAB will include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where the DSAB decides not to implement an action then it must state the reason for that

decision in the Annual Report. All documentation the DSAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

The SAR Report will be in the format shown in Appendix 11.

14. Executive Summary

14.1 Once the IMRs (where appropriate), SAR report, executive summary and action plan are agreed by the Review and Learning Sub Group, all the documents will be presented to the Prepare Group and DSAB for sign-off.

14.2 The executive summary will be the only report that will be widely available to agencies and the public. A decision will be made on a case by case basis by the DSAB, supported by legal services when it is appropriate to publish a full SAR report.

The executive summary will be in the format shown in Appendix 12:

15. Finalisation and Acceptance of the Report

15.1 The Report will need to be formally presented to the DSAB by the Independent Author with a recommendation for approval and sign off.

15.2 The purpose of presenting to the Board is to allow discussion amongst Board constituents on the case and to secure their commitment to implementing the report's recommendations.

15.3 Once the DSAB has accepted the report and its recommendations; the Review and Learning Sub Group will produce a multi-agency action plan and will monitor implementation of recommendations. Once all recommendations are implemented, the completed action plan must be reported to the DSAB for final sign off.

16. Retention of Papers

16.1 The sensitive nature of information contained within SARs must not be underestimated. There is a balance to be kept between sharing information widely in order in increase participation, ownership and learning, and the appropriate management of personal and professional detail.

16.2 The following practice will, in most instances, minimise the chances of inappropriate disclosure.

SAR Group Members will:

- Treat all papers relating to the SAR work as confidential

- Keep papers locked and secure during the process of a SAR
- Retain a single copy of the Report
- Will destroy all other papers
- Once the final copy of the SAR Report has been agreed, its recommendations accepted and approved at Board, DSAB constituents will destroy all previous draft reports

16.3 The Safeguarding Adults Board Manager, responsible for the governance of the SAR will:

- Quality assure the final report
- Retain copies of all papers associated with a SAR for a minimum period of 7 years
- Provide access to papers through application to the Independent Chair of the Board
- Mark copies of all Reports as draft until the report is approved and arrange for draft reports to be destroyed.

17. Learning from Safeguarding Adults Reviews

17.1 The real value of the completion of a SAR is that relevant professional lessons are learnt through dissemination and that local multi agency safeguarding practice is improved where required.

17.2 At the conclusion of each SAR the Review and Learning Sub Group will request from the agencies identified within the recommendations an action plan to address the areas for improvement.

17.3 Agencies should be given a timescale to respond to the Review and Learning Sub Group with a SMART action plan including proposed timescales for completion. All submitted action plans will be quality assured by the Quality and Performance sub group using the SMART principles.

17.4 Agencies subject to action plans must provide a clear audit trail and evidence to the Quality and Performance Sub Group that the action plan in respect of their agency is being or has been implemented.

17.5 Lessons learned as a result of a SAR will be used to disseminate learning through the following mechanisms;

- Via DSAB Social Media
- Through regular Learning from Practice Events
- Through participation in the DSAB Training and Workforce Development
- Annual Safeguarding Conferences
- At post-review learning dissemination workshops
- By publication on the DSAB Website
- Through the DSAB Annual Report, which highlights learning themes in both local and national reviews
- By individual agencies taking responsibility to share learning internally

17.6 The Review and Learning Group will report thematic learning on an annual basis to inform the DSAB Annual report.

17.7 Findings from SARs should be included within the DSAB Annual Report with details of what action the DSAB has taken in relation to them. Where the DSAB decides not to implement an action it must state the reason for that decision within the Annual Report.

18. Due Regard Statement

This policy has been assessed for equality and diversity as described in the Doncaster Safeguarding Adults Board Policy for the Development and Management of Procedural Documents (see Appendix 13).

19. Audit

19.1 The role of Safeguarding Adults Board is to request and receive assurance from partner agencies that robust and effective safeguarding systems and processes are in place to safeguard adults at risk across Doncaster. In addition the Board are responsible for ensuring lessons are learned from Safeguarding Adults Reviews and has governance systems to enable partners to scrutinise practice to identify lessons, missed opportunities and good practice so that it may minimise the risk of reoccurrence of abuse.

19.2 The Review and Learning Sub Group are responsible for overseeing Safeguarding Adults Reviews and monitoring the implementation of recommendations arising from reviews. The Review and Learning Group have identified the need to assure itself that lessons learned from Safeguarding Adult Reviews have been embedded and as a result practice has changed.

19.3 All SAR action plans are quality assured and agencies will be required to give written assurance of completion in relation to their action points. On final sign off of the agencies action plan by the DSAB an audit plan will be initiated.

19.4 The audit will dip sample 1 area from each agencies action plan to assure the Review and Learning Sub Group and the Board that lessons have been learned and practice has changed as a result. The evidence **must be tangible** and equate to the action identified by the agencies action plan. Written or verbal assurance will be presented to the Review and Learning Sub Group where tangible evidence is not available. Relevant clinical or professional advice and guidance will be sought as appropriate to support the auditor throughout the process.

Appendix 1 : –SAR Request Form

Referrers' Details

Name:	Designation:	Agency:	Contact Details (email, address and telephone number):

Adult at Risk Details

Adult at Risk	
Name:	
Date of birth:	
Date of incident	
Date of death (where applicable):	
Gender	
Ethnicity	
Address:	
Health (physical):	
Health (mental):	
Agencies involved:	

Person(s) or Organisation(s) Alleged Responsible to have Caused Harm or Neglect

Name:	
Address:	

Family and Significant Others

Name:	Relationship to subject person:	DOB:	Address:

Known Service Provision (subject and family/carers) – please note that this includes local and out of authority services

Children's Social Care	☐	Adult Social Care	☐
Police	☐	GP Specify the GP's Name and Address	☐
Housing Specify Service(s)	☐	Education Specify Service(s)	☐
Community Health Services Specify Services	☐	Acute Health Service Specify Service(s)	☐
Mental Health Service Specify Service(s)	☐	Drug/Alcohol Services Specify Service(s)	☐
Probation	☐	Voluntary/3rd Sector Specify Service(s)	☐

Please outline the circumstances of the incident (death, serious injury, referral to safeguarding). Include in this section detail of any internal review or single agency investigations that have been undertaken as a result of the incident and what lessons have been learnt as a result and how this has been disseminated.

Please outline a brief chronological explanation of your agency's involvement with the adult at risk, family, carers and significant others. Include your agency's involvement/ lack of involvement with other relevant agencies in relation to the service provision/events. Outline why the criteria for a SAR has been met with a focus on potential learning for agencies. Please set out the facts chronologically by person.

Safeguarding Adults Review Criteria:

Please tick the appropriate box that explains why this case requires a Safeguarding Adults Review;

☐ An adult at risk in Doncaster has died 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.

☐ An adult at risk in Doncaster has not died, but the Doncaster Safeguarding Adults Board knows or suspects that the adult at risk has experienced **serious** abuse or neglect.

☐ The DSAB are also free to consider conducting a SAR into any incident(s) or case(s) involving adults at risk. E.g. where it is believed to be in the public interest to conduct such a review.

☐ Request made by a Coroner, Family, Government Ministers or other interested parties seeking a SAR to establish whether there are important multi-agency lessons to be learned

COMPLETED REQUEST FORMS TO BE SENT VIA SECURE EMAIL TO:
dsab@doncaster.gcsx.gov.uk

Alternatively contact the Board Support Unit on 01302 736230 / 735065 to discuss the most appropriate secure method

For completion by the PREPARE Group

Review and Learning Sub Group to tick the appropriate box below that outlines the required recommended response based on the information presented:

☐ Safeguarding Adults Review

☐ Lessons Learned Review

☐ Single Agency Internal Review

☐ No Review Required

☐ Scoping / further information required

Date of meeting/discussion:
Recommendations:

- Agencies to participate in SAR:
- Methodology:
- Output:
- Timescales for completion:
- Urgent action required by agencies to prevent further abuse:
- How the Adult at Risk, Family / Friends will be involved:

Disclosure of information:

- Publish full SAR Report: Y / N
- Publish Executive Summary Report only: Y / N

Reasons for recommendation:

Prepare Group Decision:

Date of meeting/discussion:
Decision:
Reasons for decision:
Signature of DSAB Independent Chair:

Appendix 2 : – Safeguarding Adults Review Methodologies

The Care Act Statutory Guidance 2014 states;

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

The DSAB has an open and honest approach to conducting Safeguarding Adults Reviews and endorses the guidance published by Adult Social Services by the Association of Directors of Adult Social Services (ADASS). This guidance emphasises the importance of proportionality in conducting reviews and proposes that Boards have a range of options to match against the circumstances of the case.

Possible methodologies for Safeguarding Adults Reviews are set out below. This list is not exhaustive;

SCIE Learning Together Model - Systems Review
This methodology known as the "systems approach" has been specifically designed to really get behind why things are not going well. The model provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to the mistaken, or to have led to an unwanted outcome, seemed to those involved, to be the sensible thing to do at the time. It has been widely used in child protection and in response to interest from the adult safeguarding sector is now being developed in this sector. The term Learning Together is fundamentally about how the organisations learn from the incidents.

The central idea of his approach is that any workers performance is a result of both their own skill and knowledge and the organisational setting in which they are working. Therefore the approach looks at the quality of work produced by the combination of the worker and the tools. Importantly, as well as the more tangible factors such as procedures, tools and aids, working conditions, resources and skills, a systems approach also includes issues such as team and organisational cultures – these factors are all part of the system in which we work.

The aim is to make it harder for people to do something wrong and easier for them to do it right.

There are 3 elements to the methodology

- Reconstructing how professionals saw the case at the time
- Identifying and analysing key practice episodes and the contributory factors behind them
- Interpreting the broader significance

A systems approach to conducting a Safeguarding Adults Review involves:

- Scoping of review / terms of reference: identification of key agencies/personnel; roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from the Safeguarding Adults Board; frontline staff / line managers; agency report authors; other co-opted experts (where identified); facilitator and / or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons learned and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning and monitoring of implementation
- Follow up event to consider action plan recommendations
- On-going monitoring via the Safeguarding Adults Board.

http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/files/safeguarding-adults-reviews-under-the-care-act-implementation-support.pdf

Significant Event Analysis

This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development. Significant Event Analysis or Audit has been used for many years in the NHS to analyse a significant event in, 'a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements'.

The process followed in a Significant Event Analysis or Audit is as follows:

- Information Gathering – collation of as much factual information about the event as possible from a range of sources.
- Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment.
- Analysis of the Significant Event: The key questions that require answering in a Significant Event Analysis or Audit are:
    i. How could things have been different?
    ii. What can be learned from what happened?
    iii. What has been learned?
    iv. What has been changed or actioned?

Multi-agency Combined Chronology

Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, this perspective is greatly enhanced and enables us to identify not only

gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies.

A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.

Chronologies are important tools that are particularly useful when combined across agencies using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

Using Individual Management Reviews to Analyse Individual Agency Performance

Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced.

Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.

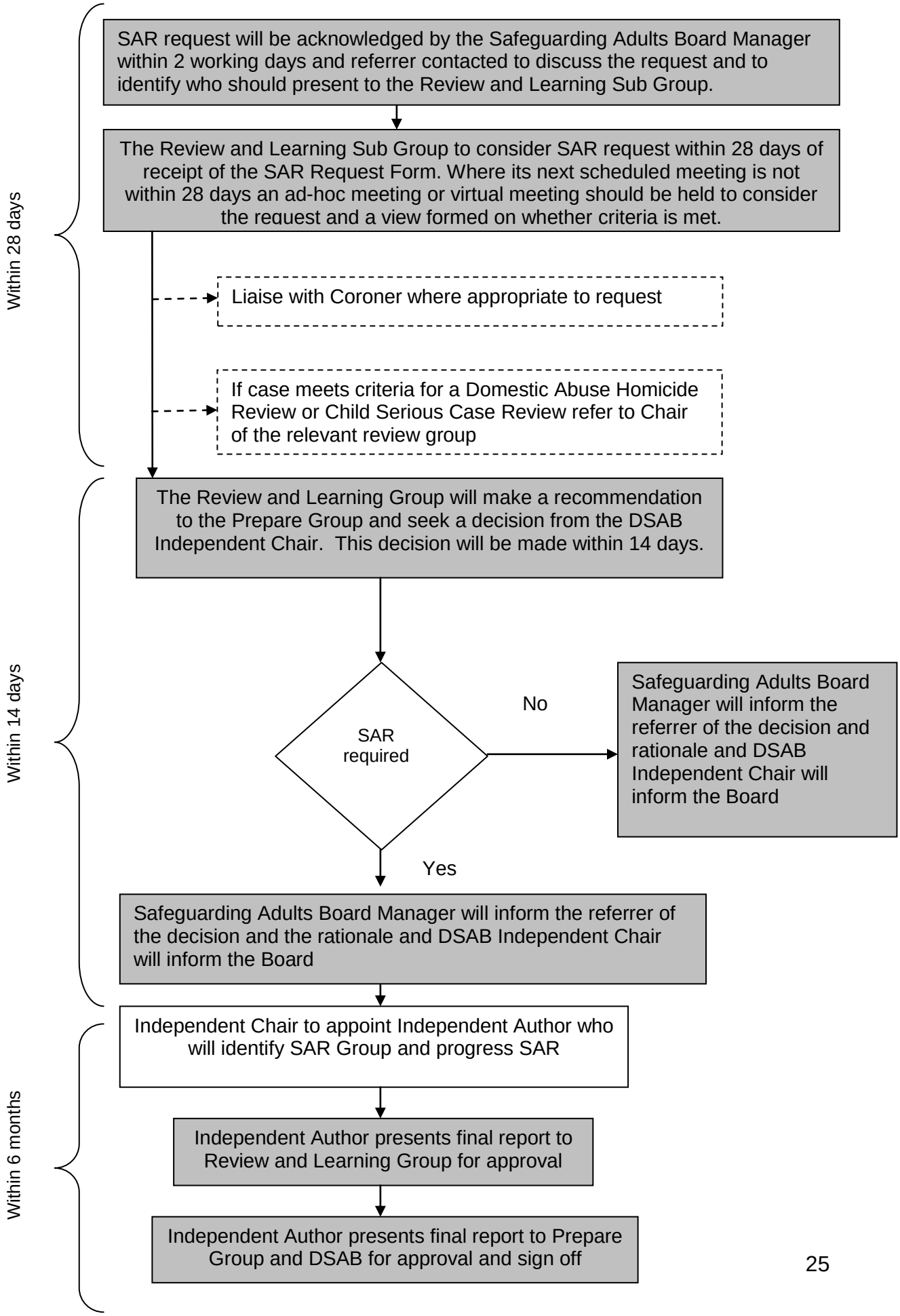
A template for an Individual Management Review (IMR) and a checklist for a good IMR are available at Appendix 7.

Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

Traditional Serious Case Review, using a Combined Chronology, Individual Management Reviews and a Review Panel

It maybe that the sub-group considers that the best way to address a complex case is for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding. This method will provide a detailed analysis of agencies' work with an adult or group of adults and provide a familiar approach to learning. However, as Dr Munro and colleagues acknowledged, there is a risk that they can be time consuming, resource intensive, conclude too late. There is a need to ensure current and timely learning and change. For those reasons, the SAR Sub-group will give very careful consideration to any added value achieved through this approach.

Appendix 3: - SAR Decision Flowchart



Appendix 4 : - SAR Terms of Reference

The SAR Independent Author working with the Safeguarding Adults Board Manager and Safeguarding Adults Review Group, will draft the initial terms of reference for the SAR covering the following points:

- Information on why the case was referred for a SAR and the date of decision
- The methodology that will be used
- The key issues to address and questions to answer by the individual agencies and the SAR report;
- The time period over which events in the case should be reviewed;
- How the victim (if applicable) and/or any family members are to be involved in the SAR process (consider also perpetrators of the abuse/neglect);
- How consent will be obtained from the victim (if applicable) and/or any family members;
- How individual agency records will be secured by the agencies involved and accessed to conduct the SAR;
- The agencies that are to be involved and what their level of involvement will be;
- If any other adult safeguarding partnerships outside of the Doncaster Borough are to be involved;
- Arrangements for the Independent Author;
- Responsibilities of the SAR Group and timescales for submitting final reports to the DSAB;
- How legal advice and any expert advice on issues from the case will be obtained;
- How the SAR Group will liaise with other parallel investigations, inquiries and reviews;
- How any media queries will be responded to by all agencies of the DSAB;
- The timescales for conducting the SAR; and
- How the SAR findings and lessons will be made available to the family, elected members, inspectorate bodies and the media.

These terms of reference can be edited by the Independent Author and the SAR Group. The final terms of reference will be approved by the DSAB and DMBC Legal Services.

Appendix 5: - Appointing the Independent Author

The DSAB has responsibility for identifying suitable candidates. For all externally appointed Authors, a minimum check will include:

- A CV
- An example of a relevant overview report recently written by them
- A written reference from a Senior Manager/Local Safeguarding Adults Board (LSAB) Chair in an Authority where they have recently written a Report
- A face to face interview or meeting with the candidate
- An up to date DBS check
- Confirmation of public liability insurance

For all in-house appointed authors, a minimum check will include:

- A written reference from their line manager expressing support in terms of supervision and time allocation for the individual to undertake the review

- Confirmation that an enhanced DBS check has been completed within the last 3 years

Commissioning Contract

Once the appointment is agreed, a contract outlining terms and conditions will be sent to the candidate. The contract to specify the tasks required i.e. Writing of Report and production of Executive Summary.

Working Co-operatively with the Report Author

It is crucial to enable the Independent Author to engage with the local system and processes so they can make sense of the information that is presented to them. However, it is vital that they also feel able to maintain their independence. The SAR Group will ensure that information on procedures etc will be made available to the Independent Author.

Independent Authors are invited to attend the following meetings:

- SAR Group meetings where draft versions of the Report are discussed.
- Review and Learning Sub Group to present final report
- Prepare Group
- DSAB to present final report

There may also be some involvement with families if the family choose to make representation to the SAR Group via the Report Author.

Appendix 6 : Agency Notification Letter - (requesting information and to seal files)

Dear Colleague **(to be sent to ALL DSAB Core Members plus Chief Officers of agencies who have been involved in service delivery to the family)**

RE: SAFEGUARDING ADULTS REVIEW GROUP (DSAB): REQUEST FOR INFORMATION

I am writing to inform you that the Doncaster Safeguarding Adults Board have commissioned a Safeguarding Adults Review. The attached provides details of the adult concerned.

You are required to check your own agency records for past or current involvement with the adult at risk and provide us with any information that may assist us in completing a Safeguarding Adults Review. If your agency has not had any involvement with the adult at risk, a NIL return is required.

If your agency is aware of any organisation, not represented on the Doncaster Safeguarding Adults Board who has had involvement with the adult at risk, please contact me as soon as possible.

If you would like further information on this matter please contact the Safeguarding Adults Board Manager via dsab@doncaster.gov.gcsx.uk

In the meantime, would you please ensure that any and all files within your organisations relating to this individual are sealed and a photocopy made if they will be needed for ongoing work**.**

If agency involvement has been recent you may wish to check with staff if any outstanding records are awaiting typing / filing or if any information is stored separately. These records should be included in the case files as soon as possible.

Please forward any information you have to the above address by……. (Date) in preparation for the meeting on ……..(date)

Yours sincerely

Safeguarding Adults Board Manager

Appendix 7 : - Standard Format for Individual Management Review (IMR)

DONCASTER
SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

INDIVIDUAL MANAGEMENT REVIEW OF AN ADULT
FEMALE/MALE (insert initials)

D.O.B

D.O.D. / DATE OF INCIDENT

This document is intended to provide an IMR of the decisions, actions taken and services provided to (***insert initials)*** who is subject of a Safeguarding Adults Review instigated by the Doncaster Safeguarding Adults Board relating to an adult who (***insert individual circumstances***).

The aim of the IMR is to look openly and objectively at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

The findings from the IMR report should be endorsed by the senior manager within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

The Individual Management Review provides a chronology of agency involvement and draws overall conclusions from the involvement of the agency with the adult at risk***.***

NAME OF AGENCY:

_____

NAME OF ADULT(S) AT RISK

_____

DOB: _____

DOD (if applicable): _____

ETHNICITY: ----------

DISABILITY: ----------

NAME, AGENCY AND CONTACT DETAILS OF PERSON COMPLETING CHRONOLOGY AND MANAGEMENT REVIEW:

_____

2. SAFEGUARDING ADULTS REVIEW TERMS OF REFERENCE

The specific terms of reference for the SAR will be inserted here.

3. FACTUAL/CONTEXTUAL SUMMARY

Provide a brief factual and contextual summary of your agency's involvement with the adult at risk for the time period identified for this SAR.

Factual summary of agency involvement

4. CHRONOLOGY OF AGENCY INVOLVEMENT

This will need to be completed in the following format

All Individual Management Reviews will be in **Arial** and **Font 12.** Where abbreviations are used please provide a glossary.

Content of report:

1. Introduction & details of agency
2. Safeguarding Adults Review terms of reference
3. Factual/contextual summary
4. Chronology of agency involvement
5. Analysis of involvement
6. What do we learn from this case?
7. Recommendations for action
8. Agency ownership of IMR

5. ANALYSIS OF INVOLVEMENT

The report writer is expected to rigorously analyse the involvement of their agency. 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. Please use the template provided, and if one section does not apply to your agency then identify that this is the case in the appropriate box.

Facts should not be stated without their origin.
Consider specifically:

Summarise your analysis of the involvement of your agency with this adult at risk.

Were practitioners sensitive to the needs of the adult at risk in their work?

When and in what way was the adult at risks' feelings ascertained and taken account of when making decisions about the provision of services? Is this information recorded?

Were practitioners knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?

Did your agency have in place policies and procedures for safeguarding adults at risk and acting on concerns about abuse or neglect? If these were not followed please provide an analysis of why staff failed to follow basic procedures.

Were there any issues in communication, information sharing or service delivery between those responsible for work during normal office hours and others providing out of hours services?

Were there organisational difficulties being experienced within or between agencies?

What were the key relevant points/ opportunities for assessment and decision making in this case in relation to the adult at risk?

Did the assessments and decisions appear to have been reached in an informed and professional way? Was there sufficient accountability for decision making?

Did action accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

Where relevant, were appropriate safeguarding adults care plans in place, and safeguarding adults reviewing processes complied with?

Was a Mental Capacity Act assessment of the adult at risk completed? Was this information recorded?

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 DSAB policy and procedures for safeguarding adults at risk, and wider professional standards?

Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult at risk?

Cite ethnicity of the adult at risk and the relevance of this to provide an explanation and exploration of ethnicity.

Cite culture of the adult at risk and the relevance of this to provide an explanation and exploration of culture.

Additionally: -

Are there any particular features of this case, or issues surrounding the death or injury of the adult at risk, that you consider require further comment in respect of your Agency's involvement.

6. WHAT DO WE LEARN FROM THIS CASE?

Are there lessons from this case for the way in which this agency works to safeguard adults at risk?

Is there good practice to highlight, as well as ways in which practice can be improved?

Are there implications for ways of working?

Are there implications for training (single or multi-agency)?

Are there implications for management and/or supervision?

Are there implications for information sharing between agencies?

Are there implications for working in partnership with other organisations?

Are there implications for service provision?

7. RECOMMENDATIONS FOR ACTION

Recommendations should be focused and specific and capable of being implemented and divided into the following:

Review – practice that should already be happening
New – actions that need to be introduced and implemented.

In completing this please consider the following:

a) What changes (if any) could be made to the agency/organisation's Safeguarding Adults procedures?
b) What changes (if any) could be made in inter-agency working in the light of this case?
c) What action within the agency/organisation should be taken in the light of its findings?
d) What areas of good practice are there? Could these be expanded?
e) What action should be taken by whom and by when?
f) What outcomes should these actions bring about?
g) How will the agency/organisation review whether they have been achieved?

Signatures required on completed report

Author of IMR

Date

Senior Manager within Agency/Organisation

Date

Appendix 8: - Consideration of Information Disclosure

Issue	**Stakeholder**				
Question	**DSAB**	**Practitioners**	**Family**	**Affected Individuals**	**Public**
Is there a legitimate purpose for the information to be shared to that stakeholder?					
Does the information enable a person to be identified? What reasonable steps should be taken for anonymity?					
Is the information confidential?					
Has consent been obtained? Remembering to confirm what constituted consent, whose consent was obtained and when it would not be appropriate to seek consent					
It there a statutory duty to share information? Consider the public interest test (see guidance): Will disclosure: − Further the public's understanding − Promote public accountability and transparency − Allow the public to understand decisions made by public bodies − Bring to light information affecting public health and safety − Affect law enforcement − Impact on the European Convention of Human Rights Is the information an exemption under the FOIA?					
What systems and processes will be used to share the information?					

The Review and Learning Sub Group and SAR Group should consider all of the stakeholders of the SAR and independently consider the following questions;

- Is there a legitimate purpose for the information within the SAR to be shared to that stakeholder?

- Does the information enable a person to be identified? Can the data be anonymised? If the information allows an individual to be identified, the agencies must take reasonable steps to explain what information will be shared, and why, taking into account data protection legislation

- Is the information confidential?

- Has consent been obtained? Remembering to confirm what constituted consent, whose consent was obtained and when it would not be appropriate to seek consent.

- Is there a statutory duty to share information? The most significant test in this area when considering SAR is the sharing of information under the public interest test. This test is at the heart of the Freedom of Information Act 2000. The DSAB should consider the following factors for and against including;

  - Will disclosure further the public's understanding of significant issues
  - Will disclosure promote public accountability and transparency
  - Will disclosure allow the public to understand decisions made by public bodies
  - Will disclosure bring to light information affecting public health and safety
  - Will disclosure affect law enforcement
  - Will disclosure impact on the European Convention of Human Rights
  - Is the information an exemption under the FOIA

  It is important to bear in mind that the competing interests are the public interest not private interests. There will often be a private interest in withholding information. Concerns that information may be too complicated for the public to understand is not a good ground for non disclosure.

  The Review and Learning Sub Group should also consider precedent and cases considered by the Parliamentary Commissioner. The default position will be to consider **the need** to know as opposed to **the want** to know.

- What systems and processes will be used to share the information? This means considering only sharing the information which is necessary for the purpose for which it is being shared, sharing it with those who need to know, checking that the information is accurate and up to date, sharing it in a secure way, establishing with the recipient whether they intend to pass it onto other people and ensure that they understand the limits of any consent and finally informing the person the information relates to (and / or the person who shared the information) if they are not aware and it is safe to do so.

- Record the decisions made in a formal way.

As part of planning for public release of information, the Review and Learning Sub Group must consult with the Information Managers of ALL relevant agencies for advice.

It is important for the Review and Learning Sub Group and SAR Panel to be aware of Data Protection and Freedom of Information requirements. Under the FOI Act any person has the right to make a request for information held by a public authority.

The organisations forming membership of the DSAB are subject to the provision of the Act and should have procedures for dealing with requests. Any organisation receiving a Freedom of Information request concerning a Safeguarding Adults Review should discuss this with the Review and Learning Sub Group who may ask the PREPARE Group for advice.

The Act recognises that there are grounds for withholding information and provides a number of exemptions from the right to access some of which are subject to a Public Interest test.

Information held and/ or gathered by agencies for the purpose of a Case Review may fall within one or more of the following exemptions:-

- Investigations and proceedings conducted by public authorities (e.g. a criminal investigation).
- Court records
- Health and safety (disclosure would be likely to endanger the physical/ mental health/ safety of an individual).
- Personal data *
- Information provided in confidence (disclosure would constitute a breach of confidence).

Some exemptions are absolute, others are qualified – requiring a balancing exercise to be carried out before a decision is made as to whether to disclose.

Agencies should consult their information officer or take legal advice if in any doubt as to whether an exemption applies.

NB Requests by an individual *involved with* the Case Review, for information concerning themselves would be dealt with in accordance with the Data Protection Act.

** Defined in Data Protection Act 1998 as "Data which relates to a living individual who can be identified from those data and any other information in the possession of or likely to come into the possession of the data controller – which includes opinions about the individual and indications about intentions in respect of the individual."*

Appendix 9: LETTER – Notification to Family Member or Friend

Date:

RE: DONCASTER SAFEGUARDING ADULTS BOARD: SAFEGUARDING ADULTS REVIEW

(In the case of a death) First of all I would like to offer my sincere condolences on the death of (adult's name).

The purpose of this letter is to inform you that because of **(insert circumstances)** ********** and the circumstances surrounding this. Doncaster Safeguarding Adults Board (DSAB) will carry out something called a Safeguarding Adults Review.

I would like to reassure you that this Safeguarding Adults Review will not influence any ongoing police investigations, or any work that may be happening at the moment between your family and professionals such as a social worker. This is a separate process, involving senior managers from all Health and Social Care Services that make up the DSAB.

The purpose of the Safeguarding Adults Review is:

- To establish whether there are lessons to be learned about the way in which local professionals or organisations work together to safeguard and promote the welfare of adults at risk

- To identify clearly what those lessons are, how they will be acted upon and what changes might be necessary

- To improve inter agency working and better safeguard adults at risk.

I have enclosed a leaflet which outlines the process for the Safeguarding Adults Review.

Please do not hesitate to contact xxxxxxxxxxxxxxxxx if you want to make some comments or observations to the Safeguarding Adults Review or if you would like any further information.

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

Yours Sincerely

Copy To:
Independent Author

Appendix 10: – Leaflets for Families

Safeguarding Adults Reviews: Information for Families

If you need this information in another format, please contact
Doncaster Safeguarding Adults Board Support Unit on 01302 736230.

What is Doncaster Safeguarding Adults Board (DSAB)?

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

What is a Safeguarding Adults Review?

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

Why Are You Carrying Out A Safeguarding Adults Review?

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

Who Will Carry Out the Review?

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

What Will Happen after the Report is Finished?

Doncaster Safeguarding Adults Board will write an action plan to make sure improvements are made to the way organisations work together to keep adults at risk safe. Each individual organisation involved in the review will also write an action plan. Doncaster Safeguarding Adults Board will make sure the actions are carried out and have a positive effect.

What Will I / We Have To Do?

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

Who Will See the Report?

Normally the Report will be kept confidential to those people who represent their organisations at Doncaster Safeguarding Adults Board or have contributed to the review and the staff within those organisations who worked with the adult at risk and their family. The Executive Summary sets out the key findings and recommendations of

the review. It does not give any personal details or information which would identify the adult at risk, family or anyone else involved. It is available to anyone who wants to read it and will be on our web site. Your personal contact will meet with you and tell you what is in the Executive Summary before it goes on the website.

How Long Will the Review Take?

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

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

Your personal contact (insert name)……..

Doncaster Safeguarding Adults Board Support Unit
01302 736230
Email: dsab@doncaster.gov.uk

Appendix 11: - Safeguarding Adults Review Report Format

Cover Page	• DSAB name and logo • Title of SAR " Safeguarding Adults Review in Respect of *Name of Adult at Risk)"* • Date of birth of adult at risk, the date of death or serious injury • Name of independent overview report author
Introduction	• Summary of circumstances leading to review being undertaken in the case • Terms of reference for the review • List of contributors to the SAR and the nature of contribution • List of SAR Group members and author of overview report • Details and experience of Independent Chair and Author • Methodology used to conduct SAR
The Facts	• Integrated chronology of involvement with the adult at risk on the part of all relevant organisations • An overview of the chronology to summarise relevant and pertinent information known to all agencies
Analysis	• How and why events occurred, what discussions, decisions and actions were taken and what discussions, decisions and actions were *not* taken. (In producing this section the quality of the IMRs/or the analysis summary throughout the chosen methodology will be vital. Poor IMRs / analysis, and lack of information in chronologies will impact on the quality of the report) • Critical appraisal of the IMRs / summaries of analysis and their contribution to learning lessons • Through the benefit of hindsight and use of evidence from research, consideration and comment (where relevant) if different discussions, decisions and actions would have led to different outcomes • Where previous SARs have already commented on practice issues relevant to this case, comments on how these could have impacted on different outcomes • Examples of good practice in the case

	• Terms of reference questions answered and conclusions from the findings
Lessons to be learnt & Conclusions	• Summary of the lessons to be learnt for practice and policy for individual agencies, collective multi agency processes and national guidance
Recommendations	• Recommendations should be few in number, focused, specific and **capable** of being implemented • Recommendations are not just about addressing failings from this case, but can have if appropriate, wider implications for practice, change and lessons learnt. • Recommendations can also include practice improvement from the SAR process it self
Action Plan	• Recommendations from the report translated into an action plan • The Action Plan should set out the activity to be undertaken, who will be responsible for the activity, when the activity is likely to be implemented by and what the intended outcome(s) of the activity is (are). The Plan should also make clear the reporting mechanism for monitoring and review

Appendix 12: - Executive Summary Format

Cover page	• DSAB name and logo • Title of SAR " Safeguarding Adults Review In Respect of *Anonymised Name of Adult at Risk)"* • Name of author
Circumstances which have led to a SAR being conducted	• Brief summary of circumstances in the case and why a SAR was undertaken
The review process	• When the decision to commission a SAR was made • The summary of the terms of reference • Agencies involved in the SAR • Agencies involved in the SAR Group • Names of the Independent Author & Chair of the SAR Group • Explanation of the other related inquiries • Family involvement in the SAR process
Case Summary	• Key summarised facts from the case (all names and places to be anonymised) • Key issues and themes from the case
Lessons to be Learnt & Conclusions	• Key summarised lessons learnt from the SAR process from this case • Clear description of both single agency and multi-agency lessons and conclusions in the context of the key themes and issues identified • Good practice in the case and where systems can improve • Answers to the terms of reference in the case • With hindsight, could or should different decisions have been taken, and at what point?
Recommendations	• Recommendations of action for agencies and collective multi agency processes • Recommendations for national attention

Appendix 13: - Due Regard Statement

Completed by	**Safeguarding Adults Team Manager Governance & Assurance**
Title of Policy / Guidance	**Safeguarding Adults Review Policy and Toolkit**
Date of Assessment	**20/06/17**
Lead Manager	**Head of Service Safeguarding Adults**
This is :	**Revised Policy**

1	**Name of the 'policy' and briefly describe the activity being considered including aims and expected outcomes. This will help to determine how relevant the 'policy' is to equality.**	Doncaster Safeguarding Adults Board are committed to promoting the health and well-being of adults at risk and to prevent harm wherever possible through: the promotion of a good understanding of safeguarding adult procedures amongst all multi-agency staff to identify the signs, or potential signs, of abuse and report into the system appropriately. The DSAB Safeguarding Adults Reviews are conducted to establish whether there are lessons to be learnt from the circumstances of a case about the way in which local professionals and agencies work together to safeguard adults at risk. Also to review the effectiveness of procedures (both multi-agency and those of individual organisations) to inform and improve local inter-agency practice. This policy provides information for the benefit of all staff (multi-agency) who may be required to contribute towards the Safeguarding Adults Review process.
2	**Service area responsible for completing this statement.**	Doncaster Safeguarding Adults Board
3	**Summary of the information considered across the protected groups.** **Service users/residents**	• DSAB Communication and Engagement Strategy • DSAB Policy for conducting SCR / LLRs • DMBC Toolkit: The Public Sector Equality Duty

	Doncaster Workforce	• Partner organisations who have experience relating to target groups • The Care Act 2014 and Statutory Guidance for conducting Safeguarding Adult Reviews Data regarding all protected characteristics will be collected regarding all subjects of Safeguarding Adult Reviews. This information will be summarised and available within the DSAB Annual Report in line with the Care Act 2014 requirements.
4	**Summary of the consultation/engagement activities**	A number of multi- agency stakeholder meetings have taken place to develop this policy and toolkit. In addition the Policy has been consulted on by the Review and Learning Sub Group and the DSAB Board constituents.
5	**Real Consideration:** **Summary of what the evidence shows and how has it been used**	This policy replaces the Policy for Conducting Safeguarding Adults Reviews 2015 in line with the requirements of the Care Act 2014 and the Boards governance structure In addition previous performance of 2015 Serious Case Reviews and Lessons Learned Review has been analysed to revise this policy to ensure it is robust and in line with best practice. Analysis of previous SAR / LLRs demonstrated that the Board has not routinely published the findings of reviews, this has been strengthened to provide an open and transparent approach. In addition the process has previously been seen as bureaucratic and rigid. The revised policy captures the new methodologies proposed by Association of Directors of Adult Social Care (ADASS) and SCIE. The policy has also been revised to capture the changes due to the Board restructure and the creation the Safeguarding Adults Review Panel. The Safeguarding Adults review process is expected to have a positive impact upon all people irrespective of characteristic through embedding a culture of learning from lessons within the organisation. Robust systems will facilitate the identification of abuse or potential abuse of adults at risk to ensure it is reported and acted upon proportionately. The Safeguarding Adults Review process will consider any barriers to communication and understanding. The Care Act 2014 requires where appropriate, for an independent

		advocate to represent and support throughout a Safeguarding Adult Review (SAR), this will be considered and offered to the adult at risk to enable involvement.
6	**Decision Making**	• The DSAB will approve this statement alongside the Policy at a Board meeting
7	**Monitoring and Review**	• This due regard statement will be revised in line with the DSAB Policy for Development of Procedural Documents. • Data regarding Safeguarding Adult Review will be monitored and published within the DSAB Annual Report.
8	**Sign off and approval for publication**	To be presented to the DSAB Board meeting on 4th September 2017 and signed off.

Review Date - September 2020