SAR Toolkit

19th April 2017 V7Luke Turnbull

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1. Foreword by CSAB Chair

I am pleased to present the Calderdale Safeguarding Adults Board Safeguarding Adults Review Policy and Toolkit. The Calderdale Safeguarding Adults Board values the Safeguarding Adults Review group's work to ensure that the Partnership learns, develops and uses a positive reflective practice approach to inform the development and assurance of safeguarding adults work in the Borough. 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. The Care Act 2014 allows for SABs to use the most appropriate and proportionate methodology in undertaking SARs. Regardless of which methodology is used to achieve learning, all Safeguarding Adults Reviews are of equal significance and value to the Calderdale SAB. The Calderdale SAB is proud of the commitment that agencies have demonstrated to the review process and is committed to continue to reflect, learn and develop safeguarding practice in Calderdale.

2. Introduction

Section 44 of the Care Act 2014 and associated statutory guidance require Safeguarding Adults Boards (SAB) to conduct Safeguarding Adults Reviews (SARs) in certain circumstances, and permits the SAB to arrange them in other circumstances. The Act requires SAB member agencies to cooperate with and contribute to the carrying out of a SAR.

The purpose and underpinning principles of SARs, and the broad requirements and guidance for conducting SARs, are set out in section 18 of the Safeguarding Adults West and North Yorkshire & York Multi Agency Policy and Procedures.

The Calderdale Safeguarding Adults Board Safeguarding Adults Review group (SARG) is responsible for recommending the commissioning of Safeguarding Adults Reviews, overseeing the process and together with the Performance and Quality group assuring the CSAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

This toolkit sets out the CSAB's:

- The purpose of a Safeguarding Adults Review (SAR)
- Criteria for conducting a Safeguarding Adults Review (SAR)
- Clarifying Roles and Responsibilities
- The referral process for requesting a SAR
- The process for commissioning the SAR
- Provides several options for conducting those reviews
- How adults, families and staff will be supported and involved in SARs
- How learning from SARs will be acted upon
- The associated guidance and templates are designed to ensure governance of the process and to provide a process for achieving a complex and challenging task most effectively.

3. The Purpose of a Safeguarding Adults Review

Safeguarding Adults Reviews provide an opportunity to improve inter-agency working, for onward dissemination of lessons learnt to partner agencies, the sharing of best practice

and ultimately better safeguarding of adults at risk of abuse or neglect. Safeguarding Adults Reviews are not enquiries into how an adult at risk died or who is culpable; that is a matter for safeguarding investigations, Coroners or Criminal Courts to determine, as appropriate. The purpose of a Safeguarding Adults Review, (SAR) is to prevent serious harm or the risk of serious harm to adults at risk of abuse or neglect by learning from complex cases that agencies find challenging, which, on initial analysis, demonstrate areas of practice that could have been delivered more effectively and additionally and where there are clear concerns that agencies have not worked as well together as they might.

A Safeguarding Adults Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented and uses that consideration to develop learning that enables the safeguarding adults partnership in Calderdale to improve its services and prevent abuse and neglect in the future.

A Safeguarding Adults Review will be focused on ensuring learning and improvement of practice and partnership responses to addressing or preventing abuse or neglect of adults at risk. This process is explicitly not about blaming any agency, service or individual. It should also be noted that this process is not intended to focus on the most dramatic, harmful or distressing cases, but on those that afford maximum learning to the Calderdale SAB.

Agencies will have their own internal procedures to review practice and raise standards, such as complaints, audits and serious incident investigations; a Safeguarding Adults Review is not intended to duplicate those processes, nor to investigate allegations of abuse or neglect. Rather, the focus is on multi-agency learning through consideration of how agencies worked together, with the intention of improving how they do so in the future.
Safeguarding Adults Reviews in Calderdale are conducted in accordance with the following principles:

- Positive reflection: the intention of Safeguarding Adults Reviews is to learn and improve services, not to blame any individual or specific agency and reviews will highlight positive and innovative practice as well as that which could have been different.

- Timeliness: priority will be given to ensuring that timescales set out are adhered to and reviews are undertaken in timely manner so that learning and improvement takes place as quickly as possible. This will be considered at the point of commissioning.

- Impartiality: the review will be conducted fairly and impartially with evidence of balance and objectivity in all reports.

- Thoroughness: the review process is robust and committed to exploring each of the terms of reference in detail.

- Openness and accountability: the review and its outcomes will be shared appropriately and the process will be conducted in accordance with the CSAB and member agencies' governance arrangements.

- Sensitivity: Safeguarding Adults Reviews will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).

- Confidentiality: Prior to information gathering, consent will be sought to access that information. All information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

4. Criteria for conducting a Safeguarding Adults Review

The Care Act 2014 states that:
(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:-

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if:-

(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if:-

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:-

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.

5. Roles and Responsibilities

CSAB Chair
The Chair of the CSAB is responsible for making a decision in response to the Safeguarding Adults Review group's recommendations for a Safeguarding Adults Review and its associated methodology.

The Chair is responsible for ensuring CSAB receives regular updates in respect of progress of Safeguarding Adults Reviews. Where agencies fail to keep to timescales the

CSAB Board Manager will escalate concerns to the CSAB Independent Chair who will seek remedial action from the CSAB member / Senior Manager within the organisation.

The Chair is responsible for ensuring the Director of Adult Social Services and elected members are briefed about all Safeguarding Adults Reviews, and where relevant, are advised of the content of all reports and action plans.

SAR Group
The Safeguarding Adults Review Group (SARG) is responsible for recommending to the Independent Chair of the Calderdale SAB whether a referral for a Safeguarding Adults Review meets the criteria. It is solely the Group's role to make this recommendation. The Independent Chair will consider the information provided by the Safeguarding Adults Review Group and decide whether or not to conduct a Safeguarding Adults Review. Where a case is considered to meet those criteria, the Safeguarding Adults Review Group will either make recommendations about the overall approach a Safeguarding Adults Review or delegate this role to the Review Panel.

The Safeguarding Adults Review Group will recommend to the CSAB Chair, where relevant, how the adult at risk, person(s) and/or organisation(s) responsible and/or family members should be involved.

The Safeguarding Adults Review Group is responsible for performance managing the Safeguarding Adults Review process and reporting progress to the Calderdale SAB at each of its meetings.

Learning and Improvement Group
The Learning and Improvement Group is responsible for disseminating learning from SARs in partnership with the SAR Group and the CSAB. This will include organising learning events following the publication of an SAR, producing a brief written guide of the learning for partner agencies and seeking assurance that lessons learned are included in all partners training courses. Learning from SARs conducted outside of Calderdale will be disseminated through the Learning and Improvement Group.

Quality and Performance Group
The Quality and Performance Group is responsible for seeking assurance that national and local lessons learned and lessons from Safeguarding Adults Reviews are embedded into practice.

CSAB
Members of the CSAB will nominate senior appropriately experienced and senior staff to represent their organisation on SAR panels in consultation with their agency's senior responsible manager. They will also ensure that appropriate staff members are available to write chronologies, write reports (such as Individual Management Reports (IMRs), take part in investigation and learning events and be interviewed by report writers.

Members of the CSAB will consult regularly with those staff from their agency who are participating in Safeguarding Adults Reviews to ensure they are informed and can provide support and guidance. CSAB members should recognise that both the roles required are often 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.

It is the responsibility of the CSAB member to ensure that the agency they represent keep to the prescribed timescales for actions required as part of the review.

The CSAB is responsible for recommending to the Director of Adult Social Services approval of all Safeguarding Adults Review reports and action plans. CSAB members are responsible for ensuring their organisation's actions within Safeguarding Adults Reviews multi-agency action plans are achieved.

CSAB members are responsible for ensuring that any disputes arising from the SAR (See Appendix 4) are resolved or are escalated to the appropriate level within their organisations for resolution.

Individual Management Report (IMR) authors
IMR authors will be appointed by the organisation's CSAB representative. IMR authors are responsible for completing their agency chronology and IMR within agreed timescales and to an appropriate standard. Sign off from a senior manager within their organisation must be sought prior to submission. (See appendix 9 for guidance on writing an IMR).

SAR Panel members
Members of a Safeguarding Adults Review panel will be nominated by their CSAB member and senior agency manager to work together in considering the issues within the Safeguarding Adults Review. The review panel, depending on the methodology used will meet on several occasions during the SAR process.

The role of the review panel is to assist the Independent Author in analysing the information collated and provide respectful challenge to other agencies. It is the role of the panel to ensure the report is factually accurate and based on the evidence gathered during the process.

Safeguarding Adults Review Panel members will be senior managers without line management responsibility for the case and without previous involvement in the matter. However, 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.

Where this role has been delegated by the Safeguarding Adults Review group, the Review Panel will recommend the detail of the approach to the review including methodology, timescales, terms of reference, etc.
Members of the Safeguarding Adults Review Panel will feedback to their agency's CSAB member on progress and key issues emerging from the Review.
Panel members will support their agency's staff members involved in the Review ensuring for instance that any reports written are of good standard and incorporate comments from panel discussions.

Organisations not represented on SAB
All organisations have a legal duty under the Care Act, whether or not they are member of the SAB, to provide information relevant to the review in circumstances described in Section 45 of the Care Act 2014.

Where organisations have collective arrangements for representation at the CSAB the CSAB member representing the organisation will assume the role described above for the agency they are representing.

The Director or Adult Social Services (DASS)

The Director or Adult Social Services (DASS) must be informed of any decision to undertake a Safeguarding Adult Review as the head of the lead agency for safeguarding adults, regardless of whether the local authority was involved previously or not. The role of the DASS is to have an oversight of the local authorities' response to the Adult Safeguarding Review, ensuring good multi-agency cooperation and providing the Independent Chair with the factual information held by the local authority.

Independent Author/Chair

The appointment of an Independent Author is required in SARs regardless of the methodology used. The appointment will be made by the CSAB. In practice the CSAB will delegate this function to appropriate CSAB members to recruit the Independent Author. The Independent Author will work with members of the Safeguarding Adults Review panel to address each of the Terms of Reference of the Review and produce an Overview Report. This Report will have recommendations / findings (depending on the methodology used) that are agreed by the Safeguarding Adults Review Panel. These will provide the Calderdale SAB with positive learning that will enable it to improve services and safeguarding in Calderdale. The Independent Author will communicate directly with Adults(s) at Risk, family members and significant others in order to address consent issues and gather the necessary information required for the overview report.

Other investigative processes – coroner, police, SI's, safeguarding investigations, DHRs, safeguarding children SCR, disciplinary

There is an overall principle that there should be, where possible, "one case, one review". That is to say that where an incident occurs that requires a multi-agency review, all efforts should be made to ensure that one review includes the requirements for all the processes. For example, an incident occurs involving the homicide of an adult at risk where the perpetrator is a partner or family member with a mental illness and children were involved. This may require a mental health homicide review, a DHR, a SAR and a safeguarding children SCR. In these circumstances, all efforts should be made to undertake one review and arrangements made for reporting through all governance structures. A decision should be made at the outset by the decision makers involved as to which process is to lead, who is to take which role, and who is to chair with a final joint report being taken to the necessary commissioning bodies.

Other investigations such as HR, Complaints, disciplinary etc. should not affect a review and these can be run in parallel, however consideration must be given to all those involved to avoid duplication of effort such as interviewing key people more than once. Continuous communication between all parties is vital.

When single agency reviews / investigations have already occurred or are ongoing, all information/data from that review (not just the report but interview records, disciplinary records, complaint records etc.) should be made available to the multi-agency review where possible.

Any Safeguarding Adults Review will need to take account of 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. A coroner is legally entitled to require information provided to Safeguarding Adults Reviews as well as the overview report itself.

Safeguarding Adults reviews can take place usually as soon as the Safeguarding Adults Review group has given the approval to go ahead. There is one exception to this and this

is when there is already a criminal investigation running which has yet to conclude. Depending on the stage of the Police investigation, it may be that the review can run in parallel however the discussion must be had with the Police representative on the Safeguarding Adults Review group to reach an agreement. The communication should be between the Senior Investigating Officer (SIO) and the Police representative.

6. Referral process

Any individual or group who believes that a Safeguarding Adult Review is warranted and meets the criteria as outlined in the Care Act (2014), should agree this with the Adult Safeguarding Manager of their organisation. When a referrer does not have access to an Adult Safeguarding Manager then an application can be made directly to the chair of the Safeguarding Adult Review Group following a discussion with their CSAB representative.

In most circumstances a safeguarding investigation (under the West and North Yorkshire and York Safeguarding Adults Policy and Procedure) will have been conducted prior to referral for a SAR. The chair of the safeguarding case conference will seek views from attendees as to whether a SAR referral is appropriate. The adult at risk and families members, carers and friends involved in the case conference must be included in this consultation.

The referral for consideration of a Safeguarding Adult Review should be made on the appropriate form (see Appendix 1). Once completed, the form should be submitted to the Chair of the Safeguarding Adult Review Group as soon as possible. All such referrals should be sent securely in line with the referrer's organisational policy.

7. Preliminary decision to proceed with SAR

Following a review of the information provided in the referral, the role of the SARG is to refer to the criteria, set out in the Care Act and determine if the criteria is met. If further information is required to establish whether the Care Act criteria is met a scoping enquiry (Appendix 5) will then be sent out to the CSAB member of appropriate agencies by the CSAB Manager / secretariat to determine whether the agency had contact with the adult at risk or any named significant others and obtain further information. If the person/ people who are the focus of the review are alive then they must be approached to inform them that a SAR is being considered. If the person has difficulty in understanding then it should be established which relatives / friends of the person need to be informed. Gaining consent information gathering is best practice but as a statutory review is not required in order access and share relevant information. It is the role of the CSAB manager to liaise at this stage with the person / family / friends. Once returned, the information provided on this scoping form will also contribute to establishing the most appropriate methodology for the review and be used by the SARG in the selection of an appropriate independent author.

Once a decision to proceed is established, the CSAB Manager will send written confirmation to all agencies (see Appendix 10). The letter will also request that records are secured, that agencies respond to confirm the date that records were secured and chronologies are requested using the chronolator.

8. Selecting a Chair/Independent Author

The Chair of the Calderdale SAB will appoint an Independent Chair and an Independent Overview Report Author with an appropriate level of experience, expertise and knowledge. The role of independent chair and independent author will usually be carried out by the same person. The Overview Report Author will be independent, that is to say they will not hold a substantive post in Calderdale and will not have had any prior involvement in the case or any individuals involved. The Panel Chair will also be independent or be co-opted from an adjoining Authority where there is no conflict of interest.

The Independent author will need to be experienced in the review methodology being used. For this reason, chronologies will usually be undertaken and some analysis by the review panel in order to decide on a likely methodology prior to the appointment of the Independent Author.

9. Establishing a Safeguarding Adult Review panel

Safeguarding Adult Review Panel will be commissioned consisting of at least Health, Police and Local Authority representatives and all organisations who had key roles in the case. The Chair of the Calderdale SAB will write to the CSAB Board member of the organisations involved for nominations to the Review Panel and will request the production of a full chronology of agency involvement and Individual Management Reviews if required under the methodology chosen.

The CSAB should also consider co-opting panel members from other organisations where additional expertise / a critical friend is required. For example where the review concerns a death of a person with a Learning Disability, the Learning Disabilities Mortality Review (LeDer) should be approached to provide specialist knowledge.

Each Panel member must be of requisite seniority to be able to fully secure their organisation's full participation in the Safeguarding Adult Review. This includes supporting the Panel Chair to convey any urgent learning points emerging from the review while it is in progress.

The panel member must not have been directly involved in the first line management or frontline care of the individual(s) concerned.
For details of the initial and subsequent actions for the Review Panel please (see Appendix 2). Once the Review Panel is established, nomination of any deputy panel member is only permitted under exceptional circumstances. It is a requirement for the panel members to prepare for each panel meeting thoroughly and input in other ways that the Review Panel Chair or Overview Report Author may require.

10. Panel Meeting

The Review Panel will be quorate when the Police, health and local authority representatives are present, together with the Chair and will meet on average between 3 and 6 times during the course of the review.

11. Establishing Terms of Reference (Appendix 6)

The CSAB Safeguarding Adults Review Sub-Group will draft Terms of Reference for each Safeguarding Adult Review or will delegate this responsibility to the Safeguarding Adults

Review Panel. These will be confirmed at a meeting of the Safeguarding Adult Review Panel following the analysis of the combined chronology.The Terms of Reference should not be set in stone and should be revised, as necessary, in order for the review to focus on the areas with the potential for the most significant learning.

The purpose of the Review is to ensure that lessons are learned from the circumstances of the case about the way in which relevant professionals and agencies have or are working together to safeguard adults at risk to inform inter agency and multi-agency practices as they relate to safeguarding adults at risk. An example of the terms of reference for a SAR is included at Appendix 6.

12. Involvement of the Individual & Family members / significant others

It is imperative to involve the individual subject to the review and family members and significant others in the review process where possible and when consent / best interests are established. This involvement has many benefits to the review process including:

- Ensuring the voices of individuals concerned are heard.
- Helping to understand the beliefs, values, likes, dislikes, personality, lifestyle of the person subject to the review.
- To ensure, where possible, any questions the individual or significant others want answering are addressed as part of the SAR.

The Safeguarding Adults Review Group (SARG) will recommend to the CSAB Manager, where relevant, how the individual, family members or significant others should be involved.

It is important that the individual and family members are informed that a Safeguarding Adult Review will be taking place within 2 weeks of the decision to conduct a review.

The CSAB Manager will liaise with the individual and appropriate friends / family to communicate that a decision has been made to proceed with a Safeguarding Adults Review. The CSAB Manager will outline to the individual / significant others :

- the process, including proposed timescales for completing the review
- the purpose of the review and
- hear their initial views
- Note any initial questions that the individual, family and friends would like the review to address
- explain how their perspective(s) will be fed into the Safeguarding Adults Review and inform them of how to express any concerns/ make a complaint about the SAR process.
- Arrangements for advocacy if required.
- The CSAB Manager will establish with the individual and significant others methods of communication
- The individual and appropriate others will be provided with information about who to contact if they wish to ask any further questions,

It is important that expectations of the individual and others are appropriately managed to reflect the purpose and aims of the review. raise concerns or make a complaint. The Board Manager will discuss with the individual and their significant others about how their views will be sought and when to expect contact for interview by the Independent Author.

Within 2 weeks of the appointment of the Independent Author, an introductory meeting should be arranged by the CSAB Manager for the individual and / or significant others to meet the Independent Author. This meeting will give the individual / significant others further opportunity to discuss their involvement in the review and ask any questions. Arrangements should be made at this stage for a further meeting for the Independent Author to interview the individual and or significant others as part of the review process.

The Independent Author should, where appropriate and relevant, seek to inform, support and encourage them in providing appropriate challenge. Developing an ability to help focus on improving practice and areas of development; fostering an approach which is focused on mutual reflection, learning and development, not blame or criticism, whilst accepting that the process for them may be difficult.

The Independent Author will keep all relevant individuals regularly informed of progress through the review.

At the conclusion of the Safeguarding Adults Review, once relevant reports and plans have been accepted by the Independent Board Chair, the SAB and the Director of Adult Social Services, the Independent Chair of the Board and / or the Independent Author will offer to meet with the individual and or significant others to explain the Review conclusions, seek feedback and support any challenge.

13. SAR Methodology

Using the most appropriate SAR methodology for the particular case will help to produce the most effective engagement in the process and produce the optimal learning. How the SAR is conducted will affect the kind of learning obtained from it and whether the process is constructive and valuable. The choice of methodology is therefore significant and must be appropriate and proportionate to the case under review. The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

- SAR chair – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience:
- Strong leadership and ability to motivate others.
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics.
- Ability to use a range of investigatory techniques and methodologies.
- Good analytical skills using qualitative data.
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge
- Commitment to/promotion of open and reflective learning cultures.
- SAR Panel – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review.

The SAR panel should consider which methodology and investigation tools are most appropriate for the review. Planning and information gathering are key. It will often be most appropriate to collate chronologies and pick out key points and issues before deciding on the most appropriate investigation tools and methodology to use in the review.

Methodology is not prescribed in the Care Act and this enables flexibility to consider a range of options that are highlighted below:-

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?

The following search link provides a raft of articles on the subject of SEA:
http://www.google.co.uk/?gws_rd=ssl#q=significant+event+audit+history

The Learning Together Model / Systems Review
The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as a means of identifying which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice. A report for the Local Government Association Knowledge Hub by Wirral Safeguarding Adults Board noted the positive experience of using a systems review approach. Features of this approach include:

- Providing a way of thinking about front-line practice and a method for conducting case reviews.
- Producing organisational learning that is vital to improving the quality of work with families and the ability of services to keep adults at risk of abuse or neglect safe.
- The model has been adapted from the systems approach used in other high risk areas of work, including aviation and health.
- Supporting an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken.
- It involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions.

It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

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 Partnership 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 Partnership Board, agree dissemination of learning and monitoring of implementation
- Follow up event to consider action plan recommendations
- On-going monitoring via the Safeguarding Adults Partnership Board.

The following link provides a good introduction and summary of the Learning Together Model:
http://www.scie.org.uk/publications/guides/guide24/introduction/index.asp

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.

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. (See Appendix 8) for guidance on writing an IMR.

Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel
It maybe that the SAR 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, there is a risk that they can be resource intensive and do not ensure timely learning.

Thematic Reviews

A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or investigation. Themes may also be identified by the Performance and Quality Assurance Subgroup. A thematic review considers an individual case as a starting point, but looks at issues raised generally, rather than the details specific to the case.

- Findings are collated from involved agencies or previous reviews
- The legal framework, risk and communication are considered
- An academic literature review is undertaken
- Policy documents are reviewed
- Interviews are held with practitioners
- Multi-agency response is considered

14. Investigation Tools

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.

In most circumstances a combined chronology will be produced to help the SAR panel decide the key areas for the review, the most appropriate investigation tools to use and the methodology to be utilised for the SAR.

Producing complex chronologies
Chronolator simplifies the collection and collation of chronological data from diverse sources. Whenever you need to assemble a chronology containing events from diverse organisations, Chronolator can help.

Reviewing interactions between different agencies and organisations often requires a comprehensive multi-agency chronology. Producing one can be a time-consuming task. Chronolator makes it easier.

It is based on Microsoft Word™, so little specialist knowledge is required to use it. There are no new programs to learn or install, and only a basic knowledge of working with Word tables is required.

Chronolator has something to help everyone involved in using a chronology to investigate a case:

- those who supervise and administer it;
- the front-line staff who input the data;
- those who review it

Please note:

Chronolator is licensed software. You can evaluate its features without having a licence, but the Chronology Documents it creates include a watermark on every page. If you do not want these watermarks to appear, you must purchase a Licence.
Chronolator is used by the Calderdale Childrens' Safeguarding Board and by the Calderdale Community Safety Partnership. Licenses for the use of Chronolator are purchased in batches and there are opportunities to joint fund.
Prior to using this software authorisation must be sought in the first instance from the Calderdale Safeguarding Adults Review group Chair.

Analytical Timelining
This tool builds on a chronology. It includes additional analysis of chronology using a constructively critical method of questioning the events leading up to the incident under investigation. For example additional headings may include contextual information such as background information, information from staff which is not recorded in the records, whether expected policy / practice standards were met and highlighting of significant concerns.

Pattern Analysis
Pattern analysis can be useful for visually depicting information relating to issues such as:

- The numbers of referrals to safeguarding services and the level of engagement of the victim
- The frequency of police attendance/ involvement and the risk level assigned each time
- Service users attendance or non attendance at outpatients appointments over time
- How agencies were leaving messages for each other specified time periods and the mod of communication

Presenting the information in a pictorial format can enable a level of clarity that text cannot. It can also provide for a more interesting report format.

Example of pattern analysis contact grid:

Person with whom person had contact	08 March 2016	09 March 2016	10 March 2016	11 March 2016	12 March
GP	X	X		X	
Day Centre		X	x		
Housing Officer	x			x	
Social worker		x			X

X = seen and asked about abuse, x = seen and abuse not discussed, x = unsuccessful attempt to see was made

Private Post Box Method
This tool involves using post boxes which people can anonymously post information about matters such as how the system works in practice, variances in practices and why they are occurring. These investigation tools can be useful when information is needed from a much larger group of people working within the system than have been involved in the actual incident or when specific memory recall is lacking due to the frequency with which staff perform a task.

Observational Methods and surveys
These are established clinical audit and qualitative research techniques that can provide good insight into team functioning, how a team goes about its business and undertakes tasks. They can be used alone or in combination with other tools to ensure a rich and accurate understanding of how a system / process is functioning.

Investigative Interviewing
The aim of investigative interviewing is to obtain accurate and reliable accounts from victims, witnesses or suspects about matters under police investigation. Accurate and reliable accounts ensure that the investigation can be taken further by opening up other lines of enquiry and acting as a basis for questioning others.

15. Overview Report

An overview report will be written and presented to the Calderdale Safeguarding Adult Board whatever the agreed method of the review. Whilst the style of the overview report may vary depending on the method used the content should include:-

a. Introduction
This Overview Report is intended to provide an overview of the deliberations and recommendations of the review drawing overall conclusions from the information and analysis contained in the individual management reviews and reports commissioned from any relevant parties.

b. Circumstances leading to a safeguarding adult review being undertaken.
Describe individual circumstances and reasons for the review being undertaken.

- List contributors to the review and the nature of their contributions including from family.
- The circumstances that led to a Safeguarding Adult Review being undertaken in this case
- Provide an overview of the specific individual circumstances and outline the concerns to be addressed.
- Give the specific facts of the safeguarding adult review
- State when the review commenced, the commissioning arrangements details of the Independent Chairperson/ facilitator/Independent Overview Report Author.

c. Terms of reference
Detail the agreed terms of reference (see appendix 5 for template)

d. Method of the safeguarding adult review

Describe the method of the review that is undertaken and a rationale for the method. The panel consisted of representatives from (list appropriate agencies). State whether family and/or others were included or involved in the process and if not provide an explanation for example criminal proceedings.

e. Facts of the individual case

Compile an integrated chronology of involvement with the adult at risk and family on the part of all relevant agencies, professionals and others who have contributed to the review process (if appropriate to the method of review). A Chronolater can be used.

Important to include:

- Relevant information relating to the adult at risk.
- Critical and life incidents
- Features of professional activity over time which should include key events, for example a referral or services provided.
- Give an overview which summarises what relevant information was known to the agencies and professionals involved
- Provide an explanation and exploration of ethnicity.

f. Analysis of individual case

This part of the Overview Report should look at how and why events occurred, decisions were made, actions taken or not.

Identify the key features of the case:

- Adult at risk's characteristics/behaviour/needs
- Wider family and environment
- Professional involvement

Analysis of interacting risk and protective factors to include:

- A summary and synthesis of the knowledge brought together by the assessment
- A description of the problem/concern
- A description of protective factors and support
- A hypothesis about the nature, origins and cause of the need/problem/concern
- A plan of the proposed decisions and/or interventions

Reference should be made to the quality of the Individual Management Reviews and how this assisted in analysing how and why events occurred and why some decisions were or were not taken.

The Overview Report should challenge agency practice and comment on whether different decisions or actions may have led to an alternative course of events.

The analysis section is also where any examples of good practice should be highlighted.

This part of the Overview Report should take account of recent and well publicised major enquiries and government guidance pertinent to the case.

This is the part of the Overview Report which can consider whether different decisions or actions may have led to an alternative course of events.

g. Communication between and within agencies/Information sharing

- Was there a shared safeguarding agenda between or within agencies?
- Was there evidence that the adult at risk's needs were paramount?
- Was there challenge of carer/care provider?
- Was information shared appropriately between agencies?

h. Implementation, conclusions and recommendations

This part of the Overview Report should summarise the lessons to be drawn and how those lessons should be translated into recommendations for action.

The Overview Report should make reference to the single agency recommendations identified through the Individual Management Reviews and identify any further single agency recommendations.

Recommendations should be few in number, focused and specific (SMART) and capable of being implemented. View on how these could be achieved should be included. Consideration should be given to the resources required to implement the recommendations such as cost. If there are lessons for national, as well as local, policy and practice these should also be highlighted.

i. Action Plan

The overall action plan should identify the main cross cutting multi-agency themes. (See Appendix 9) for suggested action plan. The Independent Chair and the SAR review panel will formulate the Safeguarding Adult Review Action plan based upon the multi-agency recommendations identified by the Independent Chair/Overview Report author.

16. Embedding Learning

The purpose of a Safeguarding Adults Review is to learn and improve practice and services. It is essential therefore that the learning from Safeguarding Adults Reviews is widely disseminated. All Safeguarding Adults Review action plans will have a specific action setting out how learning will be disseminated and embedded. Learning from Safeguarding Adults Reviews will be disseminated in the following ways:

- Via the Calderdale SAB Bulletin and specific SAR bulletins
- Through regular and specific Learning from Practice Events
- Through participation in the Calderdale SAB
- Training and Workforce Development Peer to Peer Network
- Annual Conference
- Review learning dissemination workshops
- By publication on the Calderdale Adults Partnership Board Website
- Through an annual Safeguarding Adults Review report, which highlights learning themes in both local and national reviews
- By individual agencies taking responsibility to share learning internally

The Safeguarding Adults Review Group will report thematic learning on an annual basis to the Calderdale SAB and this will inform key indicators with the Calderdale SAB.

17. Timescales

Safeguarding Adult Reviews must be completed in a timely manner. Once the decision to commission a Safeguarding Adult Review has been made, it should be completed, reviewed by the SAR Group and presented to the Calderdale SAB within 6 months, unless agreed by the Chair of the Board. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Chair of the Board.

It is acknowledged that where a Safeguarding Adult Review relates to serious Institutional abuse or where multiple abusers are involved then such reviews are likely to be more complex and may require more time.

The Independent Author together with the CSAB Manager and the CSAB must agree a timetable detailing milestones and deadlines for the review. Where timescales are at risk of slipping the CSAB must be informed and contingency plans made to ensure the review is completed in a timely manner.

18. Governance

Safeguarding Adults Reviews are resourceintensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

i. Safeguarding Adults Review Group

The Safeguarding Adults Review Group is accountable to the Calderdale SAB and this accountability is set out in the Board's terms of reference.

The Chair of the Safeguarding Adults Review Group will ensure the Chair of the Board is informed of any referrals for Safeguarding Adults Reviews, significant developments and progress of reviews.
An overview of each Safeguarding Adults Review will be reported to each meeting of the Calderdale SAB

ii. The Decision to Conduct a Safeguarding Adults Review

All Safeguarding Adults Reviews will be conducted through the Safeguarding Adults Review group and only the Safeguarding Adults Review Group, with representation from Adult Social Care, Police and Health can recommend a Safeguarding Adults Review. The Safeguarding Adults Review Group is responsible for making a recommendation to the Chair of the Calderdale SAB and that individual will make a decision about whether or not to conduct a Safeguarding Adults Review.

The decision will be communicated to the referrer and the Calderdale SAB. When a decision is made to conduct a SAR the Care Quality Commission, Director of Adult Social Services and NHS England (where the Review concerns any primary care organisations) will also be informed.

iii. Safeguarding Adults Review Reports and Action Plans

All reports of Safeguarding Adults Reviews are owned by the Calderdale SAB and held securely by the Calderdale Safeguarding Adults Partnership. Reports and action plans are final when accepted by the Board Chair and the Calderdale SAB and agreed by the Director of Adult Social Services. Final Safeguarding Adults Review reports should: provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (this will be reflected in the recommendations and action plan); be written in plain English and in a way that can be

easily understood by professionals and the public alike; and be suitable for publication without needing to be amended or redacted.

When compiling and preparing to publish reports the Calderdale SAB will consider carefully how best to manage the impact of publication on Adult(s) at Risk, family members and others affected by the case. The Calderdale SAB will comply with the Data Protection Act 1998 when compiling or publishing the report, and will comply also with any other restrictions on publication of information, such as court orders.

Individual Agency Management Reviews and Reports are owned by the agency that authored them.

The Calderdale SAB is responsible for recommending approval of all Safeguarding Adults Review Reports and Action Plans. The Safeguarding Adults Review Group is responsible for monitoring and confirming completion of all Safeguarding Adults Review action plans. The Director of Adult Social Services will receive a recommendation from the Calderdale SAB to accept the conclusion of a Safeguarding Adults Review, including the content of any final report and multi-agency action plan. The Director of Adult Social Services will advise the Board Chair of that acceptance. This will be recorded within the minutes of the following Calderdale SAB meeting.

All action plans will explicitly set out how agencies will evidence completion of an action and how the learning from the Safeguarding Adults Review will be embedded within the organisation.

Action plans will be monitored by the Safeguarding Adults Review Group. Any failure to complete actions will be escalated to the Chair of the Board with the knowledge of the relevant Calderdale SAB Board member.

Where this relates to organisation that is commissioned by the Calderdale SAB member, this will also be raised with the commissioner and regulator where appropriate.

When an action plan has been completed, this will be reported to the Calderdale SAB prior to closure of the Safeguarding Adults Review. The Review can only be closed when the Calderdale SAB is satisfied and has agreed that all actions have been completed.

19. Dealing with disagreements

The receiver of a SAR referral (usually the chair of the SAR subgroup) will check that the referrer's line manager or CSAB member has been informed of the referral. Where the SAR Group cannot make a unanimous decision, the CSAB Chair should be advised of this.

During the SAR process, panel members should feel able to challenge decision-making and to see this as their right and responsibility in order to promote the best multi-agency safeguarding practice. An aim of a SAR review panel meetings is to question and challenge other agencies actions in relation to the review. This should be done constructively and amicably.

At all stages of the SAR process, resolution of any disagreements should be sought within the shortest timescale. Disagreements should be resolved at the lowest possible stage with the assistance of the Independent Author but where resolution is not possible, the Chair of the CSAB Adult Safeguarding Review Group needs to be made aware in timely manner and will act as mediator. Where the Chair of the CSAB SAR group is unable to facilitate a resolution, escalation is required to the Independent Chair of the Safeguarding Adults Board who will determine whether or not the decision can be made at that time or requires discussion by board members at the Safeguarding Adults Board.

20. Publishing the report

The purpose of a safeguarding adult review is to highlight lessons learnt from multi-agency communication and enquiries. The final draft of the report is submitted to the Calderdale Safeguarding Adults Board within the agreed timescales. The Communication and Engagement Group and Learning and Improvement group will then agree an effective communication strategy to ensure lessons are learned. The report will, in normal circumstances, be published on the Safeguarding Adult's Board website and all statutory agencies on the Safeguarding Adults Board, the CQC, NHS England and the DASS will be informed of this.

21. Media

Each agency represented on the Safeguarding Adults Board need to consult their individual media policy and procedure.

Publication of the safeguarding adult review will normally be managed through publication on the Calderdale Safeguarding Adults Board Website. At the point of publication the Board Chair will normally write a press statement outlining the reasons for the key findings and required actions. It has been agreed that the norm will be to publish a full anonymised report unless there are exceptional circumstances not to do so.

The lead agency for safeguarding adults is the local authority and will therefore take the strategic lead with regards to the media. The local authorities' media policy and procedure (appendix 6) must be followed with regards to media interest following a SAR publication.

22. Mental Capacity

The Mental Capacity Act 2005 applies to all individuals aged 16 years and above. It is important that the five principles of the Mental Capacity Act 2005 are considered fully as part of any Adult Safeguarding Review. The five principles under section 1 of the Mental Capacity Act 2005 are:-

Principle 1: A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

Principle 2: Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

Principle 3: Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Principle 4: Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

Principle 5: Less restrictive option – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

Two Stage Test
In order to decide whether an individual has the capacity to make a particular decision you must answer two questions:

Stage 1 Is there an impairment of or disturbance in the functioning of a person's mind or brain? If so,

Stage 2 Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them.
- Retain that information long enough to be able to make the decision.
- Weigh up the information available to make the decision.
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or other professionals.
The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in your records why you have come to your conclusion that capacity is lacking for the particular decision.

Best Interests
If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests (principle 4). The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made.

The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person determining capacity

must consider. In addition, people involved in caring for the person lacking capacity have to be consulted concerning a person's best interests.

23. Glossary

24. References

i. The Care Act 2014 - Department of Health
ii. Safeguarding Adults West & North Yorkshire & York Multi-Agency Policy & Procedures - The West and North Yorkshire and York Safeguarding Adults Project Group December 2015
iii. Local Government Association Knowledge Hub by Wirral Safeguarding Adults Board
iv. Mental Capacity Act 2005 – Department of Health

Appendix 1 – SAR case consideration request form

Safeguarding Adults Review (SAR)

Calderdale SAB Case Consideration Request Form

Date request form sent	
Name and job role of referrer	
Contact details of referrer **Address** **Telephone** **Email**	
Agency of referrer	
Senior Manager authorisation (where applicable) **Name** **Job Title** **Address** **Telephone** **Email** **Date referral authorised** **Managers comments**	

Subject: Person(s) Details that require consideration for an SAR

Name of subject	
Date of Birth of subject	
Gender	
NHS number/Social Work ID	
Address	**Current/last known address**
Family /significant others	**Relationship:** **Details: (include address/contact phone numbers)**

Details of person/organisation alleged to have caused harm

Name: **Organisation:**

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	☐	Education	☐
Specify Service(s)		Specify Service(s)	
Community Health Services	☐	Acute Health Service	☐
Specify Services		Specify Service(s)	
Mental Health Service	☐	Drug/Alcohol Services	☐
Specify Service(s)		Specify Service(s)	
Probation	☐	Voluntary/3rd Sector	☐
Specify Service(s)			

1. Background to case for consideration (please clear text from box before adding information)

• *Identify individual, Name of GP Practice / Hospital* • *Brief review of history of individual that is known including health history e.g. – input from Housing services previously, suffered from depression, alcohol addiction in the past* • *Any other Safeguarding processes or Police/Coroner's investigations that are known to have/be taking place.* • *Have any other SARs taken place?*

2. Brief overview of circumstances of the incident (please clear text from box before adding information)

• *Provide key details of case* • *Only identify what is known* • *If there appear to be gaps in information about the case – please specify clearly eg. The lady could not be contacted by any of the agencies involved in delivering a service during the period of ….* • *If other agencies are involved*

3. Current Position of the case, (please clear text from box before adding information)

• *e.g. Police are still investigating, The hospital have registered the case on their internal incident reporting system, the Safeguarding Team in the local Authority have completed an investigation* *Any actions that have already been taken by agencies*

4. Referral reason(s) How does this case meet the criteria for a Safeguarding Adults Review?

See policy

5. What learning do you think can be achieved through review of this case? Which agencies/services are/ were involved in this case? Which agencies/ services should particularly achieve this learning?

Please detail

6. What other learning/review processes have been followed?

Please detail

7. What did they achieve? How has that learning been disseminated?

Please detail

8. What impact has it had?

Please detail

9. Please detail any other relevant information that will enable the Safeguarding Adults Review Group of the CSAB reach a decision about how to respond to this referral.

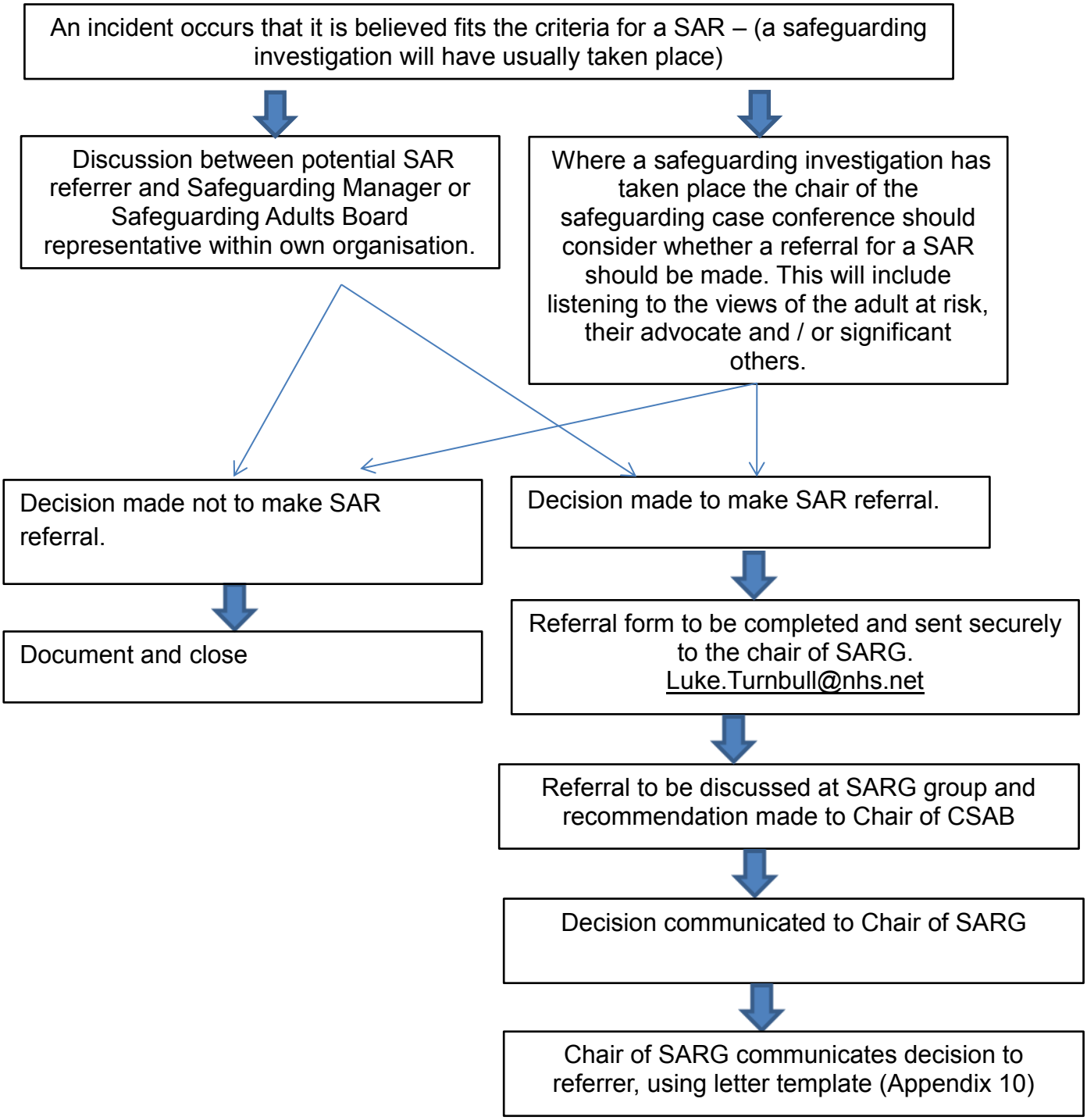
Please detail

10. Please return your form and any other appropriate documentation to the following secure email address:-

    Please mark your email, 'SAR referral' and return to: julie.hartley@calderdale.gcsx.gov.uk

    NOTE: This email address will only accept emails **from** a secure email account.

Appendix 2 – SAR referral process flowchart

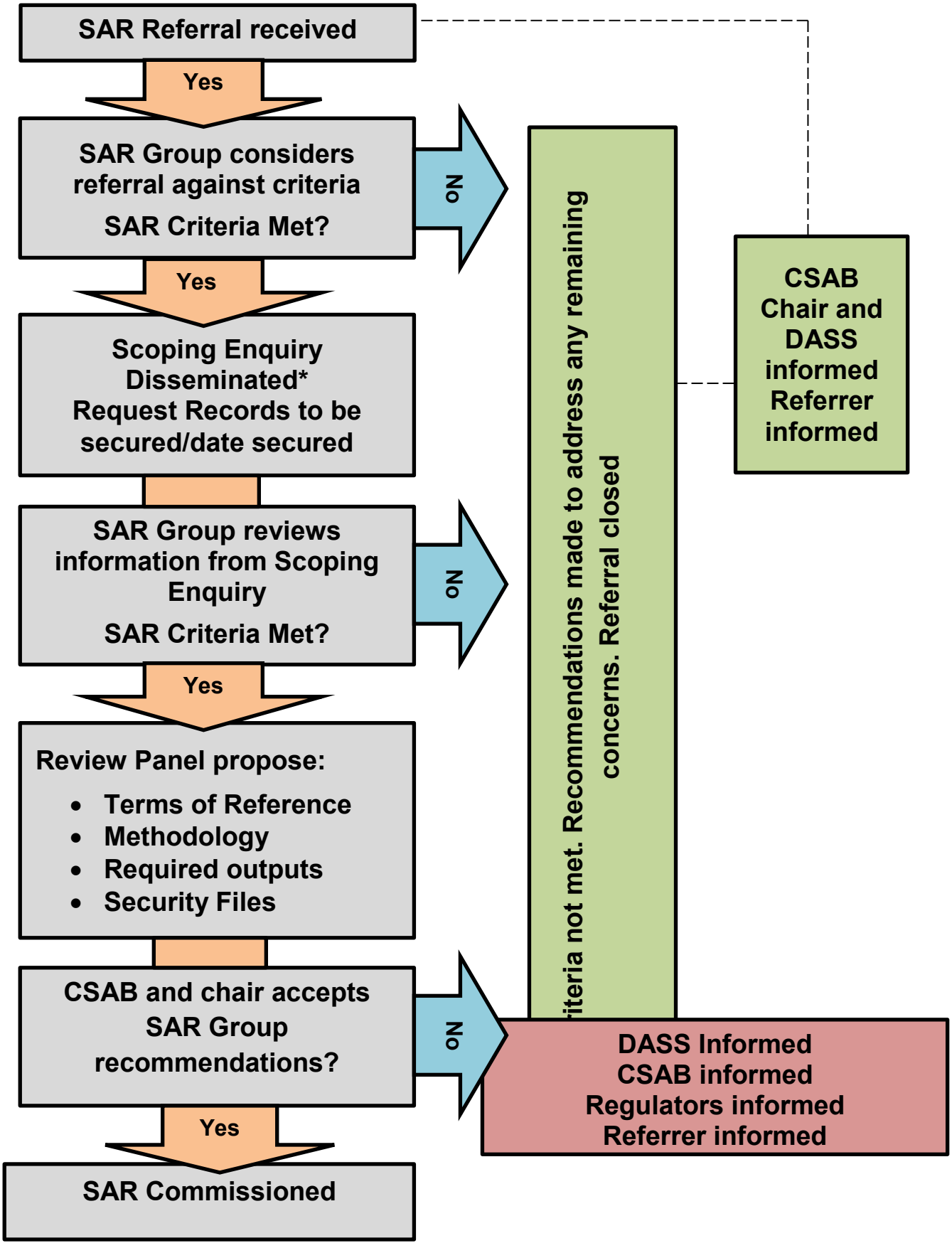


Appendix 3 - High Level Flowchart of Process

Appendix 4 – CSAB SAR Flowchart

Calderdale CSAB SAR Group

Flowchart for SAR



Appendix 5 – Letter Requesting Scoping

*Scoping enquiry will only need to be circulated if the SAR panel require further information in order to make a decision on whether to conduct a SAR.

Letter Requesting Scoping

(Date)

Dear CSAB Member,

The Safeguarding Adults Review Subgroup of the Calderdale Safeguarding Adults Board has met to consider a Safeguarding Adult Review (SAR) concerning [Name, DoB] on the [date]. The sub group has concluded that a scoping exercise is required in order to decide whether the case meets the Care Act criteria for a Safeguarding Adults Review. Please find attached a Safeguarding Adults Review Scoping Enquiry form, which the group requests is completed by your agency. Please can you ensure that this form is completed in full and returned to [safeguarding email address] by [date]. It is important that this deadline is met in order to meet timescales.

The Safeguarding Adults Review Sub Group will meet again on [date] and will make a recommendation to the Independent Chair of the Calderdale Safeguarding Adults Board whether or not to carry out the review. Within 1 week of the decision being made I will write to you again to inform you of the decision. If a decision is made to carry out a SAR, I will write to you with details of the next steps in the process.

If you have any questions about the process please contact [SAB Manager name and contact details].

Yours Faithfully

[SAB Manager]

Safeguarding Adults Review Scoping Enquiry Form

Please complete this form and return it via **secure** email to: : julie.hartley@calderdale.gcsx.gov.uk

Please review your agency's records and complete the form. This information will be collated and used by the Safeguarding Adults Review group to inform the decision about whether or not any form of review should be undertaken by Calderdale Safeguarding Adults Board.

Dates of scoping information	To be completed by person sending out request
Referrer	To be completed by person sending out request
Adult(s) at Risk **Name:** **D.o.B.:** **D.o.D.:** **Address:**	To be completed by person sending out request
Person(s) / Organisation(s) Alleged to have Caused Harm: **Name:** **D.o.B.:** **D.o.D.:** **Address:**	To be completed by person sending out request
Other relevant family / friends:	To be completed by person sending out request
Referral reason:	To be completed by person sending out request including brief details of the case
Scoping referral sent to (list agencies / services):	To be completed by person sending out request
Responding agency: To be completed by person sending out request **Name of person completing this form:** **Job title:** **Contact details**	

This information will be collated and used by the Safeguarding Adults Review group to inform the decision about whether or not any form of review should be undertaken by the Calderdale SAB.

Question	Response
Did your agency have any contact with the adult at risk?	
If so, in what capacity? (Please detail all services)	
Has your agency identified any safeguarding concerns in relation to or any other family member / significant other? (please detail)	
Has your agency identified any areas of learning in the way in which services were provided to the adult at risk or significant others?	
Has your agency undertaken any form of learning / incident review in relation to this case? (If so, please detail, including recommendations and actual / anticipated impact).	
Is your agency of the view that any form of multi-agency review should be undertaken? (Please explain your response)	
Please detail any other information / comment that you consider would assist the sub-group in deciding how to respond to this referral	

Appendix 7 – Letter to CSAB member requesting information and IMR (if required)

Dear CSAB Board Member,

RE: Safeguarding Adults Review (Name, address and DoB of the adult who the review concerns)

Following a decision by the Calderdale Safeguarding Adults Board to conduct a Safeguarding Adult Review concerning the multi – agency response to the above named person, your agency has been identified as being required to participate in this review. Please could you take the following actions:

1. Ensure that your agency's records pertaining to the person are secured.
2. Nominate a suitably qualified and experienced person from your organisation, who has not been involved in the case to:
    a. complete a chronology of your organisation's involvement from xx/xx/xxxx to xx/xx/xxxx
    b. Become a panel member for the Safeguarding Adult Review.
    c. Write Individual Management Review (IMR) author from your organisation. In this case, the method for the review will be decided after the chronologies have been returned therefore an IMR may not be required. However identifying a potential IMR at this stage will help the process proceed in a timely fashion.

Please note that the panel member and the IMR author should not be the same person.

Please inform XXXXX within one week of receipt of this letter the name and contact details of the people you have nominated.

Please can you ensure that your agency's chronology is completed in the required format (attached). The completed chronology should be sent by **secure** email to julie.hartley@calderdale.gcsx.gov.uk or **password protected** to julie.hartley@calderdale.gov.uk by xx/xx/xxxx. I would appreciate your assistance in ensuring that the chronology is completed and returned within timescales.

If you have any questions about this request please contact XXXXXX

Yours faithfully

(Name)

Calderdale Safeguarding Adults Board Manager

Appendix 8 – Terms of reference

The Terms of Reference will include:-

a. Details of the person(s) subject to the Safeguarding Adult Review – name, date of birth, date of death (if relevant), address
b. How consent will be gained from those people to be included in the review.
c. Brief details of the concern that triggered the Safeguarding Adult Review
d. Specific areas of concern for the Safeguarding Adult Review to focus upon
e. Period of time the Safeguarding Adult Review is to consider
f. The method of the review to be undertaken
g. Membership of Safeguarding Adult Review Panel or invitees for event(s) appropriate to the method of the review – agencies, experts and specialists
h. Chair of the Safeguarding Adult Review Panel / facilitator of the event(s) or other appropriate other as relevant to the method of the review
i. Independent Overview Report Author
j. Arrangements regarding advocacy support (if appropriate)
k. Strategy for involvement of family members
l. Reference to any parallel investigations
m. Start and completion dates for the Safeguarding Adult Review
n. Key areas to be analysed
o. Strategy for implementation of lessons learnt
p. A strategy for publication of the Overview Report and Executive Summary
q. A strategy for managing media interest.

Appendix 9 – Media Protocol

1. Calderdale Metropolitan Borough Council media protocols

For reasons of probity and fairness, the Council's media relations must be conducted in the light of government legislation and the Government's Code of Recommended Practice on Local Authority Publicity. These protocols are consistent with these standards.

2. News Releases

a. News Releases should normally be issued where there is a Council or a Cabinet view (ie as matter of agreed policy or of operational service). On matters of an operational nature (and in keeping with existing policy), Chief Officers should take the initiative to prepare press releases and liaise with the Press Office as appropriate. Those issues likely to attract public debate and comment/criticism within the media, or Cabinet items, should be dealt with by the appropriate Cabinet Member in conjunction with the relevant Chief Officer. Wherever possible, all quotes should be
attributed to the appropriate Cabinet Member. The Press Office should advise on how positive media coverage may be maximised. In all cases, the appropriate Cabinet Member the Chief Executive or Deputy Chief Executive and the Press Office should be notified of the content and timing of the release of sensitive material.

b. News releases on issues relating to the work of the Scrutiny Panels and the Council's Committees should be dealt with by the appropriate Chair after checking for details with the relevant Chief Officer(s). Quotes will be attributed to the appropriate Chair.

c. To promote the image of the Authority, Chief and Senior Officers should be encouraged to identify areas of activity which could attract positive media coverage for the Council. They should inform the Press Office who will advise/assist in identifying and obtaining the appropriate media coverage.

d. Where possible, news releases on issues not (a) related to Cabinet decisions nor (b) arising from existing policies of the Council, nor (c) arising from the work of the other Committees and Panels should be dealt with by the appropriate Cabinet Member after checking for details with the relevant Chief Officers/Members. Again, quotes will be attributed to appropriate Cabinet Member or Chief Officers.

e. Where a press release is issued by a Service, copies should be sent to the relevant Cabinet Members and the Chair of the appropriate Committee/Panel. They should also be sent to the Press Office Where possible, the Press Office/Chief Executive's Office will ensure that copies of all release are given at the same time as release to the Political Assistants of all Party Groups.

f. It is to be emphasised that the Press Office is there to act on behalf of Calderdale Council - not individuals or Party Groups. Where approaches are made to the Press Office to issue statements for Groups or individuals; the matter should immediately be referred to the Chief Executive/Deputy Chief Executive. Similarly, any officers, with the exception of Political Assistants, who are asked to engage in this type of activity, should contact their appropriate line managers.

3. Answering Media Inquiries

a. As far as practicable, the Press Office should be seen as the first point of contact for the media.

b. Clear, simple and accurate messages have to be conveyed when dealing with media queries. While this is clearly desirable, it is not always possible, given the

deadlines which some reporters have to work to. However, it should be clearly understood that the consideration is not the deadline, but getting across the Council's position which is more important. It may that the Council is not in a position to provide a knee-jerk response to an issue raised by the media, in which case the Press Office will explain this to the media and provide an appropriate and considered response as soon as possible.

c. Where officers are approached by journalists seeking comment on major or sensitive policy issues or a Council view on an issue where no decision has been taken, they should refer the inquiry on to their Chief Officer, who will then speak to the appropriate Cabinet Member or Chair of the relevant Committee/Panel. The Chief Officer will then liaise with the Press Office regarding a Council response to the inquiry. Where the Press Office is approached direct by the media, he will consult with the Chief Officer and, where appropriate, with the appropriate Cabinet Member or Chair of the relevant Committee/Panel.
d. Where a report has been produced and circulated on an agenda, but a decision on a matter of policy has not been made, then the same protocols should be followed.
e. Officers should not comment to the media on policy issues - except where those officers are accredited employee representatives (for example, officers of Unison) - without first consulting their Chief Officers, who should then consult the appropriate Cabinet Member or Chair of the relevant Committee/Panel and the Press Office as appropriate. Officers may give the media factual information on operational issues or on promotional releases after advising their Chief Officers.
f. Chief Officers should have the primary responsibility for media issues on operational matters and nominate a directorate spokesperson/media liaison officer. Media enquiries should be logged and referred back to the Press Office. The log retained by the Press Office will be available for inspection by Elected Members.

Guidance to writing Independent Management Reviews

Agencies with knowledge of or contact with the Adult at Risk subject to a safeguarding adult review will be requested for all records pertaining to work with the Adult at Risk to be secured and for the completion of a chronology or Individual Management Review.

The Individual Management Review (IMR)

Each organisation that is required to complete an Individual Management Review will need to: -

- Appoint a manager from within your organisation (or an independent person) to undertake the task of completing your IMR. This person should not have been directly concerned with the Adult at Risk, or be the immediate line manager of the practitioners involved.
- Ensure that all relevant files are secured and made available to the organisation IMR report writer.
- Ensure that IMR authors are allocated adequate resources (time, admin support) to complete their report within the required timescales. It is imperative that timescales are adhered to in order that the role and actions of the agencies involved with the family can collectively be reviewed by the Group.
- Make available to the IMR report writer, the chronology template and the IMR template (which would have already been forwarded to your organisation) which must be used for the compilation of the IMR.
- Notify the staff involved and ensure that any staff involved with the adult at risk should be given the opportunity to discuss their understanding of what has happened. It is essential that support and counselling be offered, given the possible serious impact on the professionals involved.

How to complete an IMR

- Use a template to follow when writing your IMR and it is important to ensure that you adhere to this so that the necessary topics are covered.
- You will also have a copy of the Terms of Reference (TOR) for the case and you should ensure that you address these within your review. These will also contain a timescale detailing from which dates you should start and finish to critically analyse your agency's involvement and it is imperative that these timescales are adhered to.
- Make sure that you include a genogram of the family make up as far as your agency understands it, including grandparents, other significant adults and friends. It is also important to record where agencies missed opportunities to see a child and observe its behaviour and development and make efforts to ascertain an Adult at Risk's wishes and feelings.
- Use a chronology to capture the timeline. Ensure that the chronologies tell the reader who knew what and when, are explicit as to when the Adult at Risk was seen, what their condition was, and what they said. Missed opportunities to see and speak to the Adult at Risk should also be recorded.

- It is important that the IMR contains an analysis of practice within the case and not just an outline of what happened. You are required to provide a detailed analysis of the actions of individual staff members and an honest self-appraisal on their part as to why they acted in the way they did and communicate this to the reader.
- You will also need to make recommendations on behalf of your agency. Ensure that they are realistic, based on the information contained within your report and that your agency is ready to implement them without delay. Recommendations need to be to be clear, concise and Specific, Measurable, Achievable, Realistic and Timely (SMART).

Appendix 11 - Safeguarding Review– Action Plan Review Identifier: AAR

Recommendation	**Relevant agencies**	**Action(s)**	**Deadline**	**Evidence of compliance to be provided**
Recommendation from the Safeguarding Review (To be completed by review panel)	*List all agencies relevant to this action (To be completed by review panel)*	*Clearly explain actions to be undertaken to implement the recommendation. Use a different line for each separate action i.e. development of new guidance, dissemination of guidance, monitoring etc. (To be completed by SAR panel / agency as appropriate)*	*Indicate when action is likely to be completed. Explain any progress that has been made to complete the action. (To be completed by agency)*	*List evidence that will be sent to LSAB to demonstrate action has been completed. E.g. dates of training held, titles of documents that have been updated, details of systems that have been put in place, summary findings/outcomes of audits that have been undertake. (To be completed by agency)*

Appendix 12 – Letter template to Chair of CSAB with recommendation

Safeguarding Adults Board

From:

Name:

Address:

Dear ……

I am writing to you following a referral for a Safeguarding Adults Review from [**name of professional**] from [**name of agency**].

The referral was discussed at a meeting of the SAR subgroup on [date and time]. The SAR group made a decision to recommend a SAR is conducted / not conducted (deleted as applicable). A summary of referral and reasons for the recommendation are outlined below.

Summary of SAR referral

Rationale for recommendation

I would be grateful if you would write to me with a decision as to whether a SAR should be conducted on this occasion. I will then inform the referrer of the decision made.

Yours sincerely

[Name]

Chair of the Calderdale Safeguarding Adults Group

Appendix 13 – Letter template. Chair of SARG to SAR referrer with decision

Safeguarding Adults Board

SAR

To
Name:
Address:

From
Name:
Address:

Date:

Dear

Thank you for the referral to the Safeguarding Adult Review (SAR) group of the Calderdale Safeguarding Adults Board (CSAB) dated […] concerning [**Name and dob of adult at risk]**

The SAR group met on [**date**] and a recommendation was made to the chair of the CSAB. A decision has been made to conduct / not conduct a SAR on this occasion. The rational for this decision is outlined below

Rationale for decision

If you disagree with this decision then you should write to [**insert name**] Chair of the CSAB outlining the reasons for your challenge.

Thank you again for taking the time to make the SAR referral.

Yours Sincerely

[**Name**]
Chair of the Calderdale Safeguarding Adults Review Group

Appendix 14 – Information for Adults, family, carers & friends about SARs

What is the Calderdale Safeguarding Adult's Board?
The Calderdale Safeguarding Adults Board (CSAB) brings together organisations that work with adults with care and support needs and their families across Calderdale, including the Police, Health Trusts, the Council, Probation Services and Adult and Community Care Services. The CSAB aims to ensure that everyone works together to reduce the likelihood of people experiencing abuse and to work with adults at risk of abuse to agree ways to support the personwho is experiencing abuse.
The Calderdale Safeguarding Adults CSAB is established in line with duties set out in the Care Act (2014). The Care Act (2014) states that the main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

- have needs for care and support (whether or not the local authority is meeting any of those needs) and;
- are experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

What is a Safeguarding Adults Review?
A Safeguarding Adults Review is a process that considers whether or not harm experienced by an adult, or group of adults with care and support needs, could have been predicted or prevented. The aim is to develop learning that enables the safeguarding adults partnership in Calderdale to improve its services and prevent abuse and neglect in the future. Safeguarding Adults Reviews are not enquiries into how an adult died or who is culpable; that is a matter for Coroners or Criminal Courts to determine, as appropriate. As of 1 April 2015 there is a legal requirement for Safeguarding Adults Boards to undertake Safeguarding Adults Reviews.

Who carries out the Safeguarding Adult Review?
A Panel of practitioners from Health, Police and Adult and Community Care Services, plus other representatives who may have knowledge relevant to the particular situation, will be involved in the Safeguarding Adult Review. There are various different ways in which a review can be conducted to maximise learning for organisations and the proposed method will be discussed with you. The panel will receive reports from organisations involved in the review and make judgements about the care delivered. The panel will be chaired by someone who is independent of the organisations that have worked with the adult. This person will also write a report based on the information provided by the organisations involved. Most importantly, the report will detail what organisations can learn from the review and develop an action plan to make sure that changes are made to reduce the risk of abuse to others in the future.

How long will the Safeguarding Adult Review take? The Safeguarding Adults Review should normally be completed within 6 months of the original referral. Sometimes this timescale needs to be extended.

How are adults and their families involved?
The Safeguarding Adults Review process will give the adult, families and close friends and carers, the opportunity to share their views and comment on the services you received. You will be offered the services of an Independent Advocate if you need assistance with the process and do not have anyone else who is able to assist you.

When the Safeguarding Adult Review is complete the report authorl will meet with you to outline the findings and recommendations and listen to your comments.

The Safeguarding Adults Board strongly believes that the involvement of the person (and their family members, carers and friends) is extremely beneficial to the review process. It helps those conducting the review to understand your experience, more about you as person and your wishes and feelings. You will be given opportunities to discuss how you would like to be involved in the review. However some people decide that that do not want to be involved in the review and we will respect this decision.