SAFEGUARDING ADULTS REVIEW

PROTOCOL

Document Control

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Foreword

This document provides guidance on WSAB's Safeguarding Adults Review Protocol. This document will assist people to decide when to refer a case for consideration as a Safeguarding Adult Review to WSAB, as well as providing guidance about the Safeguarding Adults Review process itself.

As of 1 April 2015 there is a legal requirement for Safeguarding Adults Boards to undertake Safeguarding Adults Reviews. This is in accordance with Section 44 of the Care Act (2014). WSAB recognises the importance of early lessons being learnt and appropriate remedial action implemented from reviewing cases of neglect and abuse and therefore is committed to carrying out Safeguarding Adults Reviews, when appropriate, within Worcestershire.

Safeguarding Adult Reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from individual cases can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to complete or to publish a review until after Coroner's Hearing or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented.

Derek Benson
Independent Chair
Worcestershire Safeguarding Adults Board

1. Introduction

When something has not worked well for an individual receiving care and support, it can be a very difficult time for the people involved. They may be seeking answers to questions that are not readily available and can be left feeling frustrated.

If an adult who needs care and support either dies or suffers harm, and when abuse or neglect is thought to have been a factor, the Worcestershire Safeguarding Adults Board may need to review what has happened. This is called a Safeguarding Adults Review or SAR for short.

A SAR will not blame any organisation or person for something that has not worked well.

These reviews are to see whether any lessons can be learned about the way organisations worked together to support and protect the person who died or suffered harm. The SAR concentrates on whether care professionals can learn anything from what happened and find better ways to meet the needs of others in the future.

It is important for those involved in the situation to remember that there are many other processes which might be taking place at the same time such as:

- Criminal Proceedings
- Investigations by individual agencies
- Disciplinary investigations
- CQC investigations
- Health & Safety Executive Investigations
- Fitness to practice investigations
- Coroner's Office investigations

All of the above are critical in a situation where an individual with care and support needs has experienced death or a serious injury and may also be a way of resolving disputes and complaints.

1.1 S44 of the Care Act 2014 introduces statutory Safeguarding Adults Reviews (SARs). The responsibility to carry out SARs lies with the Worcestershire Safeguarding Adults Board (WSAB).

1.2 The Act makes provision for a range of methodologies and places a requirement on WSAB member agencies to cooperate with and contribute to a SAR.

1.3 WSAB has established a Case Review Subgroup (the subgroup) which is responsible for gathering information, making a recommendation to the WSAB Chair on whether the SAR criteria are met, agreeing and managing the process and assuring WSAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

1.4 This protocol sets out the WSAB SAR process and governance arrangements. It should be considered in conjunction with Chapter 14, paragraphs 14.133 to 14.149 of the Care and Support Statutory Guidance. The protocol replaces the WSAB Serious Case Review and Lower Level Review protocols.

2. Purpose of a Safeguarding Adults Review

2.1 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

2.2 The purpose of a SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

2.3 The SAR will:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way local professionals and agencies work together to protect adults with care and support needs;

- If so, to use the review of the case as a learning process to trigger recommendations that specifically identify where systems, procedures and practices might be improved to contribute to more effective individual and inter-agency working and to better outcomes for adults with care and support needs;

- Ensure that any urgent issues that require immediate actions are dealt with as soon as they are identified; and

- Prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.4 A SAR is not an inquiry into how an adult died or suffered injury or who is culpable. It is not a reinvestigation of the case, and a SAR does not seek to apportion blame or hold individuals or agencies to account. There are other processes that exist for these purposes, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

2.5 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 from them. If individuals and their organisations are fearful of Safeguarding Adult Reviews, their response will be defensive and their participation guarded and partial.

2.6 It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. Agencies may also have their own mechanisms for reflective practice. This SAR protocol is not intended to duplicate or replace these. Such review/investigation procedures and /or reflective practice can be used alongside and to contribute to a SAR and can be considered as an alternative option for a reviewing a case should a request for an SAR be deemed not to meet the criteria.

3. Principles of a SAR

3.1 SARs should reflect the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability. SARs should both consider and reflect the Making Safeguarding Personal approach.

3.2 WSAB and partner organisations should also apply the following principles to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- The approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;

- Reviews of serious cases will 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;

- The adult with care and support needs should be supported to be involved with a SAR and advocacy arranged if required;

- Families, carers and other people with significant involvement should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively; and

- The WSAB is responsible for the SAR and must ensure it takes place in a timely manner and seek assurance of the completion of the appropriate improvement action.

4. Criteria for conducting a Safeguarding Adults Review

4.1 SARs are not restricted to cases where action has been taken under adult safeguarding procedures and it is not necessary for the adult to have been in receipt of care and support services for the criteria to be met.

4.2 WSAB must arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. The Care and Support Statutory Guidance, Chapter 14, paragraphs 14.133 and 14.134 provides further clarification.

4.3 WSAB **must** undertake a review of a case involving an adult with care and support needs in its area under the following circumstances;

There is reasonable cause for concern about how WSAB Board members or other persons with relevant functions, worked together to safeguard an adult,

And

- The adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

  Or

- The adult is still alive, and WSAB knows or suspects that the adult has experienced serious abuse or neglect

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

4.4 WSAB may arrange for there to be a review of any other case involving an adult with care and support needs. In this case WSAB would only consider a SAR if there are clearly identified areas of learning, practice improvement or

service development that have the potential to significantly improve the provision of care and support and this cannot be achieved by other review procedures.

5. Links to Other Reviews

5.1 There are separate statutory requirements for **Domestic Homicide Reviews (DHRs) and child Serious Case Reviews (SCRs)**. There may be circumstances where a SAR and a DHR or SCR are required, e.g. because they concern the same source of risk. Consideration should be given to how the processes can be managed in parallel in the most effective manner to enable organisations and professionals to learn from the case. This could involve joint arrangements for some aspects of the review or a joint review with key lines of enquiry relevant to the SAR

5.2 If the SAR criteria appear to be met a referral should be made. The Case Review sub-group will consider whether the criteria for DHR/SCR are met if this has not already taken place. The group will consider whether the criteria for a SAR are met and the Chair will discuss the management of the review with the relevant representative of the DHR and/or SCR process.

5.3 A SAR must take account of any criminal investigation related to the case to ensure that the relevant information can be shared without incurring significant delay in the review process.

5.4 A SAR should also take account of any other review process e.g. Learning Disabilities Mortality Review (LeDeR) and should inform the development of the Terms Of Reference.

5.5 Management of a **complaint** to may be postponed pending the outcome of a relevant S42 safeguarding enquiry. [Use this link to 'Guidance for someone who has a concern about an adult to decide if this needs a Safeguarding Referral or other actions]. However, a SAR should not be an impediment to progressing routine complaint processes. In circumstances where a SAR and a complaint investigation are proceeding in parallel the subgroup Chair needs to ensure arrangements are in place for good communication between the two processes to ensure consistency of information.

5.6 Any consideration or link with other review processes must be detailed in the

recommendation to the WSAB Chair.

6. Coroner's Inquests

6.1 A **Coroner's** court is a legal body that helps to determine how, when and why a person died, but not who is responsible. The investigation is held in public at a coroner's court in cases where:

- A death was sudden, violent or unnatural; or
- A death occurred in prison or police custody; or
- The cause of death is still unknown after a post-mortem.

6.2 The Coroner may have specific questions arising from the death of an adult with care and support needs. These are likely to fall into 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

6.3 A SAR must take account of any coroner's inquiry or criminal investigation related to the case to ensure that the relevant information can be shared without incurring significant delay in the review process. The Chair of the subgroup will liaise with the Coroner regarding any relevant SAR referrals.

6.4 When the Coroner has decided that an inquest will be held on a case where a SAR is taking place, relevant information should be shared. The Chair of the subgroup will share the draft or final overview report with the Coroner in order to contribute to the inquiry.

6.5 The Coroner may decide that the content of the report indicates that further enquiries are necessary. In these circumstances the Coroner is likely to request that IMRs are shared. Based on the judgement in *Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013] EWHC1711*, the Chair of the subgroup will write to the agencies that submitted IMRs to advise that it is the intention of the Board to release the IMRs. The Coroner may wish to release IMRs to interested persons within the inquest, but give those providing IMRs the opportunity to be heard prior to reaching that decision.

6.6 When a draft report has been shared with the Coroner, it may be necessary for agencies to share the draft report with involved practitioners. This will enable them to appropriately prepare for the inquest.

6.7 Article 2 inquests are enhanced inquests held in cases where the State or 'its agents' have 'failed to protect the deceased against a human threat or other risk' or where there has been a death in custody. Cases where the deceased has been under the care or responsibility of social services or healthcare professionals are also often included in this category of inquest.

6.8 Where the need for an Article 2 inquest is identified as a consequence of the SAR process, it may be necessary to delay the completion of the review. In this situation the Chair of the SAR will be asked to produce an interim report in order that the key findings and learning points can be presented to the subgroup and Board and improvement actions progressed.

7. SAR Methodologies

7.1 There is no set process for undertaking SARs. The methodology should be determined according to the specific circumstances of each case. No one model will be applicable for all cases, the Subgroup will need to weigh up what type of 'review' process is proportionate to the complexity of the case and will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. Resource implications will be considered as part of this process, but will not be the determining factor.

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.

Each of the following methodologies are valid in itself, and no approach should be seen as more serious or holding more importance or value than another. The Subgroup will make a recommendation on the methodology to the WSAB Chair.

7.1.1 Traditional Serious Case Review model

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

<u>This model includes</u>

- The appointment of panel, including a Chair (who must be independent of the case). Expert membership may be required. The panel determines terms of reference and oversees process
- Appointment of an Independent Report Author to write the overview report and summary report. There can be a joint Chair/Author.

- Involved agencies undertaking chronologies and Individual Management Reviews outlining their involvement, key issues and learning
- Production of a report and recommended actions
- Formal reporting to WSAB
- Subgroup monitoring implementation across partnerships and reporting to WSAB

The benefits of this model are:

- It is likely to be familiar to partners
- Possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- Robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- Methodology stems from children's arena so process to adults is not so familiar
- Resource intensive
- Costly
- Can sometimes be perceived as punitive and
- Does not generally facilitate frontline practitioner input.

7.1.2 Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- 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 prevailing 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 of the Subgroup; 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 and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to WSAB, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Subgroup and reporting to WSAB

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- Cost effective
- Enhances partnership working and collaborative problem solving
- Encompasses frontline staff involvement
- Allows for enhanced learning to take place through the process

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

7.1.3 Peer review approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is being used increasingly within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- peers can be identified from constitute professionals/agencies from WSAB members or
- peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- increased learning and ownership if peers are from WSAB
- objective, independent perspective

- can be part of reciprocal arrangements across/between partnerships
- cost effective

The drawbacks of this model are:

- capacity issues within partner agencies may restrict availability and responsiveness
- skill and experience issues if SARs are infrequent
- potential to view peer reviews from members of WSAB as not sufficiently independent especially where there is possible political or high profile cases

7.1.4 Thematic Reviews

A thematic review can be undertaken when themes are identified from previous SARs, referrals that did not meet the criteria for a SAR 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

The benefits of this model are:

- Increased opportunity for wider learning
- Cost effective
- Engagement with staff and managers at different levels within organisations

The drawbacks of this model are:

- Workloads of those involved may create capacity issues
- Resource intensive
- Unfamiliar methodology

8. Duty of Candour

8.1 All members of WSAB are expected to create a culture of openness, transparency and candour within their day to day work and with WSAB. In interpreting this “duty of candour”, we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice - as a member of WSAB all agencies have a responsibility to ensure openness and transparency when certain incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incident that meet the criteria for a SAR. WSAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying its own learning and multi-agency learning.

9. Responsibility for a SAR

9.1 It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is outside the Safeguarding Adults Board area. If that is the case, any SAR should be carried out by the Board that is responsible for the location where the serious incident took place. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

10. Making a Referral for a Safeguarding Adults Review

10.1 WSAB is the only body which can arrange/commission a SAR. Professionals should use form SAR 1 to make a referral. It is expected that any referral is discussed and agreed with the agency safeguarding lead prior to submission Members of the public should contact the worker involved with the adult's care to discuss the situation. If deemed appropriate, the worker will then make the referral.

10.2 The referral document should be submitted as soon as the SAR criteria appear to be met. The referrer should provide all relevant available information. It is important to note all the agencies that are known to be involved in the case. This will enable further scoping to be undertaken effectively.

10.3 Completed referral forms SAR 1 should be forwarded to the Chair of the Case Review Sub Group via the WSAB Administrator. Referrers may need to contact the WSAB Administrator on 01905 844474, or vial email at SafeguardingAdultsBo@worcestershire.gov.uk to agree secure submission of the referral.

11. Screening the Referral

11.1 On receipt of a referral the Administrator will send confirmation of its receipt to the referrer and inform the Subgroup Chair. The Subgroup Chair will screen the referral and contact the referrer if the referral appears inappropriate or further information is required. The Chair will ensure that the incident took place within the WSAB area.

11.2 The scoping document, SAR2, guidance, SAR3b and letter SAR4 will be sent to relevant agencies for return within four weeks of receipt. For WSAB member agencies, it will be sent to the Board Member and copied to the agency safeguarding lead. The document will be sent to a senior manager within other agencies. Any agency not familiar with the process will be contacted by phone to discuss the SAR process and requirements. The current or previous GP will always be asked to provide scoping information. Agencies must ensure that officers completing the scoping document are clear about the expectations. Clarification can be sought from the Subgroup Chair if required. All member agencies will not exceed the timescale for scoping. All member agencies will submit the scoping document by the specified date.

11.3 All notified agencies must take appropriate action to ensure that their files in respect of the case are immediately secured to guard against potential loss or interference.

11.4 A Subgroup scoping meeting/conference call will be arranged and the WSAB Chair and the Director of Adult Services informed of the referral and arrangements.

Case Review Group Members will have 2 weeks to review all scoping documents in readiness for the Scoping Meeting held at the end of the 2 week period.

11.5 Target timescale: 6 weeks

12. Recommendations and Decision Making

12.1 Scoping documents are returned to the Administrator. Information is collated and distributed to the Subgroup for review 2 weeks prior to the scoping meeting to enable sub group members time to review all scoping documents. The Chair of the Case Review subgroup, (or Vice Chair in their absence) will consider whether the referrer should be invited to the scoping meeting.

12.2 Subgroup members discuss the referral and scoping information at the scoping meeting/conference call. Quoracy for the meeting is determined by the Subgroup Terms of Reference. Members will present scoping information from their agencies and the Chair will present information from agencies not represented. The views of the adult and/or family are also shared if known. The Subgroup will consider whether the S44 criteria are met.

12.3 The Subgroup should aim for a consensus, not a majority view in its recommendation; the nature of a Safeguarding Adults Review is that it is multi-agency and therefore it is important that the Subgroup agrees the way forward as a partnership. If a consensus is not reached, this should be recorded with the recommendation.

12.4 If the view of the Subgroup is that the S44 criteria are met, consideration will be given to which methodology would be proportionate to the circumstances and effectively identify the relevant learning. The Subgroup will also agree the key themes, the composition of the panel and any need for advocacy. The subgroup should always have a representative on the panel.

12.5 The Subgroup Chair completes the recommendation form SAR1 which is sent to the WSAB Chair -. The WSAB Chair makes a decision on behalf of WSAB on whether to agree the recommendation(s) of the Subgroup. The WSAB Chair may seek further information from the Subgroup as required. In the absence of the WSAB Chair, the Director of Adult Services may make the decision on

behalf of WSAB if this is required to ensure a timely response to the referral. The decision is recorded on the SAR 1. The referrer will be informed of the outcome of the decision by letter, SAR6.

12.6 Occasionally the subgroup will make a provisional recommendation pending further information. This may be the case where, for example, there is an ongoing criminal investigation or an inquest is in progress.

12.7 Target Timescale: 8 weeks

12.8 The Quality Assurance and Performance sub group are able to request and obtain information in order to carry out audits around the decision making process as necessary.

13. Complaints about the decision

13.1 If any WSAB member, involved agency or person disagrees with the decision made on behalf of WSAB following a referral for a SAR, or the process followed, then a complaint can be made to the Council's Consumer Relations Unit, using this link, and ultimately to the Local Government Ombudsman.

SAR Process Flowchart – Scoping

SAR Referral sent to Worcestershire Safeguarding Adults Board (WSAB) Administrator (Stage 1)

- Referral is e-mailed securely to sarah.wilks@worcestershire.gcsx.gov.uk on form SAR 1
- Notification of this e-mail sent through to swilks@worcestershire.gov.uk
- Confirmation of receipt of the referral is sent by email to the referrer.

Form Reviewed by Case Review (CR) Subgroup Chair (Stage 2a)

- CR Subgroup Chair identifies if initial criteria are met
- If needs met, informs WSAB Administrator to start Scoping Process

Scoping Process Begins (Stage 2b)

- WSAB Administrator makes telephone contact with agencies not familiar with the process to advise
- Sends Scoping Template - SAR2, Guidance SAR3b and letter SAR4 securely to all agencies advising of required return date (4 weeks from that date)
- Books meeting for CR Sub Group to review scoping template at least 2 weeks from return date to allow for reading
- May contact the Performance & Quality Assurance (P&QA) Chair to request any information relating to themes
- Informs referrer that scoping is taking place

Scoping Templates returned (Stage 3)

- All scoping documents are returned securely by agencies and P&QA Chair

- WSAB Administrator distributes to CR Subgroup members to review 2 weeks prior to meeting

CR Subgroup meets (Stages 4 and 5)

- CR Subgroup meet to determine if a SAR is required and, if so, required methodology
- CR Subgroup Chair makes recommendation to WSAB Chair on Form SAR1. This is within 8 weeks of referral
- WSAB Chair returns SAR1 to CR Subgroup Chair informing decision made.

14. Conducting a Safeguarding Adults Review

14.1 The Subgroup will support the review process as required and ensure that communications statements are agreed on behalf of WSAB.

14.2 The SAR Panel:

14.2.1 A multi-agency SAR panel will be set up to manage the SAR:

- agree the Terms of Reference
- set timescales
- ensure that the review process is conducted in accordance with the Terms of Reference
- provide professional challenge
- scrutinise the report
- identify learning
- make recommendations

14.2.2 The panel should be made up of a minimum of 3 people excluding the chair. The subgroup will always have a representative on the panel, but the panel should not replicate the subgroup in order to maintain objectivity within the process. Panel members should be independent of the case, independent of the IMR authors and knowledgeable in the relevant subject area. The membership of the panel will include:

- A SAR chair who is independent of the case and the organisations/agencies involved
- Senior representatives from the organisations and agencies with significant involvement in the case under review.
- A legal representative, as necessary.
- The Care Quality Commission, where appropriate.
- The police, where appropriate and where it would not conflict with any ongoing investigation.
- An “expert” member to advise on particular issues if necessary.
- When care and support has been provided to the adult by a family member or friend, the Panel should consider including a carer as an expert panel member.

14.2.3 Expert membership may be required to support the panel to fully understand the circumstances of the case and the IMR findings. Recommendations for expert membership will be considered by the Subgroup Chair and selected in line with Worcestershire County Council's procurement guidance. If possible the panel will identify which expert will be needed or may be needed at the start of the process. However expert advice can be called upon at any time during the process.

14.2.4 Panel members should provide support to agency IMR authors and ensure that single agency action plans are updated during the process to reflect the findings of the SAR. However, the role of a panel member is wider than representation of a single agency as the panel must consider the multi-agency perspective. It is important the panel members allow time to consider the relevant document in order that full consideration can be given to the issues.

14.2.5 If a panel member has concerns regarding the conduct of a review, these should be formally escalated to the Chair of the subgroup or the agency subgroup representative.

14.2.6 The Subgroup Chair will send a letter, SAR7, to the Chief Executive or equivalent of the relevant agencies to request panel representation, and

where applicable, nominate an IMR author. The letter will be copied to Subgroup members/agency safeguarding leads

14.2.7 The IMR author must have sufficient knowledge and skills based around report writing, data gathering and the analysis of information gathered.

14.3 The Chair of the Panel:

14.3.1 Each SAR will require a skilled and competent Chair of the panel considering the SAR, receiving IMRs and agreeing the report and recommendations. When identifying the chair of the panel consideration should be given to the following:

- Independence of the case;
- The need for independence from WSAB;
- The relevant skills, knowledge and expertise;
- Capacity to undertake the role.

14.3.2 The Chair of the Panel will provide information to the panel and authors on their roles and responsibilities. Reference can be made to the SAR protocol.

14.3.3 Where appropriate, the chair will liaise with the local Coroner's Office and/or the police to ensure that the arrangements for undertaking a SAR are acceptable and do not conflict with any other investigative processes being undertaken. The Chair will also establish links with any other reviews concerning the case.

14.3.4 The Chair will ensure that the Subgroup are briefed on progress and escalate any issues or potential for the review not to be completed within the agreed timescales.

14.4 Report Author

14.4.1 In most situations it will be appropriate for the Chair of the panel to also act as the report author.

14.4.2 In the following situations it may be beneficial to consider an author who is NOT the chair:

- Very difficult and complex cases to enable the chair to concentrate in chairing
- Due to the specialist nature of the subject.
- To enable the Chair to be from the SAB or member agency

14.4.3 An independent author must be:

- Independent of the case
- Independent of the organisations involved
- Appropriately skilled and competent.

They may also be independent of the SAB.

14.5 Procurement of Chairs, Authors and Expert Panel Members:

14.5.1 The Subgroup will select Chairs, Authors and Expert panel members for SARs and procurement will be in line with Worcestershire County Council's procurement guidance.

14.6 Standards for Chairs and/or Authors

- Reviews will be undertaken in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. Learning identified at the Practitioner Event should be included in the relevant section of the standard WSAB SAR report template

- Review should consider wider practice as well as the practice relevant to the individual case

- Reviews are not conducted to apportion blame, but will establish whether there are lessons to be learnt from the circumstances of the case about the way local professionals and agencies work together

- Review will trigger recommendations that specifically identify where systems, procedures and practices might be improved to contribute to more effective individual and inter-agency working and better outcomes for those using services.

- There should be engagement with practitioners, generally though a facilitated learning event for practitioners, managers and safeguarding leads from the organisations involved.

- Urgent issues that require immediate actions must be dealt with as soon as they are identified.

- The Chair will also liaise with the family or other person with significant involvement as appropriate and share the draft findings from the Review prior to final professional scrutiny to ensure the voice of the victim and family are heard.

- An overview report must be produced which brings together and analyses the findings from the reports from the agencies involved in order to identify the recommendations for improvement action.

- The report should be completed on the standard WSAB SAR report template in a format to enable publication in full without redaction.

- Clear succinct account, which is relevant and proportionate to the review that has been commissioned and the individual the SAR relates to.

- The findings from the review will be presented to the relevant Board by the reviewer.

- In some instances the reviewer will be asked to lead on the development of the review action plan.

- WSAB contributes to the National Library in relation to SARs and as such agreed themes within the review should be identified within the relevant section of the standard WSAB SAR report template.

Quality & Performance Indicators

- The review reflects a culture of continuous learning and improvement.
- The review and recommendations are proportionate to the scale and level of complexity of the issues being examined.
- Professionals have been fully involved in the review process.
- Families, and where appropriate adults/children, have contributed to reviews.
- Any recommendations stemming from the report are SMART.

14.6 Terms of Reference:

14.6.1 Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken. Well formulated terms of reference are essential to ensure that the review is:

- properly scoped
- manageable
- conducted by the appropriate people; and
- within agreed timeframes.

14.6.2 The Terms of Reference should enable the review panel to:

- establish facts of the case
- analyse and evaluate the evidence
- assess risk
- make recommendations

- ensure the review will answer "**THE WHY**" question.

14.6.3 The Terms of Reference can be set out on form SAR8.

14.6.4 A Task and Finish group of the Case Review Subgroup will complete an initial draft of the Terms of Reference to include:

- Issues identified in scoping
- Any other relevant SARs
- Any national trends / themes identified
- Any local trends / themes identified by the P&QA sub group

14.6.5 The draft Terms of Reference will then be passed to the panel for further scoping in order to produce the final version.

14.6.6 Additions can be made to the Terms of Reference during the review, if required, with the agreement of the Chair of the Subgroup

14.7 Engagement with the Adult and/or Family or other Person with significant involvement

14.7.1 The panel should agree how the adult and/or family or other person with significant involvement will be informed of the review and degree to which they will be involved in the review. It is expected that the Chair will lead on the engagement with the adult/family. Family members who have played a significant role in the life of the adult should be notified that the review is taking place. Involvement can be:-

- Formal notification only
- Inviting them to share their views in writing or through a meeting.
- Contribution to the development of the Terms of Reference and overview report.

14.7.2 The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.

14.7.3 Adults and families should be offered support as required.

14.7.4 While it is important for the adult and/or family or other person with significant involvement to be engaged with the review, this should not delay progress and the opportunity for timely learning and improvement action.

14.7.5 The level of involvement with the adult and/or family or other person with significant involvement will be evidenced in the SAR.

14.7.6 Information should be provided to the adult and/or family or other person with significant involvement – see SAR 3A

14.8 Independent Advocacy

14.8.1 The local authority has a duty to arrange, where appropriate, for an independent advocate to support and represent an adult who is the subject of a SAR where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. Where an independent advocate has already been arranged under s67 Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate should be used.

14.8.2 It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process.

14.8.3 The panel will be responsible for considering the need for advocacy and notification will then be made to the subgroup. The provision of advocacy will be via the Council's commissioned service for statutory advocacy.

14.9 Practitioner Involvement

14.9.1 Practitioners will be involved in all SARs, but the level of their involvement can be varied.

14.9.2 The following should be considered by the panel and the subgroup:

- Interviewing and taking a statement from practitioners as IMRs can result in staff having heightened anxiety.
- The appropriate line manager to be informed and provide appropriate support to the practitioner.
- Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome.
- Police attendance at Practitioner Events - a judgement should be made on a case by case basis as to the timing of Practitioner Events & attendees, bearing in mind any ongoing Police investigation/ family court proceedings. This should be discussed with the SAR Independent Author & Police Senior Investigating Officer, keeping the CR Subgroup Chair informed.

14.9.3 Practitioner Events can:

- Be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event.
- Assist practitioners to contextualize what happened and achieve closure.
- Result in quicker and more enhanced learning.

14.9.4 Practitioner Events will:

- Bring together safeguarding leads, authors and frontline practitioners
- The findings/learning areas will be presented in order to consider practice from the perspective of different roles.
- The event will consider policy, procedure, practice, communication and information sharing.
- The event will identify what is required from senior managers and/or organisations in order to support good practice.

- The event will identify key learning points that are to be included in the report.

14.10 Chronologies:

14.10.1 Chronologies can support the SAR process, but are not essential or proportionate to all reviews.

14.10.2 A chronology can provide a timeline and a sequence of events. A clear chronology of events in a safeguarding case can show agencies where risks and can be used to cross reference significant events.

14.10.3 If using a chronology consider:

- The timeframe
- What you mean by key/significant events
- Using an agreed terminology avoiding abbreviations – for example Nurse A in one organisations chronology may not be the same Nurse A in another organisations chronology.

14.10.4 A chronology should be completed within the IMR.

14.11 Independent Management Reviews (IMRs)

14.11.1 IMRs will be requested for most, but not all SARs. When required the Chair of the panel will formally request that agencies conduct an IMR of their involvement with the adult, family and/ or service and submit a report on the findings.

14.11.2 IMR authors must be supported by the panel and their agencies in carrying out this function.

14.11.3 At the start of the SAR process, a meeting will be arranged as set out in the Terms of Reference between the Panel chair and all IMR authors to explain the process and expectations of the IMRs. A briefing will be given

to the IMR authors regarding the case that is the subject of the review. Submission of completed IMRs in not less than 8 weeks of the Author's Meeting.

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

14.11.5 It should be made clear to authors that the IMR process is not about investigating abuse or apportioning blame. However, information that emerges in the course of reviews may indicate that disciplinary action should be taken under established agency procedures or that a notification should be made to a professional body. In some cases, for example alleged organisational abuse; disciplinary action may be needed urgently to safeguard other adults.

14.11.6 An IMR should note any good practice in addition to any areas where improvement action is required.

14.11.7 Where authors interview others, a written record of interviews should be made and this should be shared with the relevant interviewee.

14.11.8 The IMR report must comply with the SAR terms of reference, which will be sent with the initial request for an IMR to be carried out. It is recommended that the IMR should not be longer than 10 pages. The IMR should be completed on form SAR9.

14.11.9 A final IMR report should be produced bringing together the findings and learning, and should be signed off by the senior officer in the organisation and returned to the WSAB Administrator within the timescales set. Any foreseeable delays should be communicated to the Chair of the Panel.

14.11.10 Following completion of their reports, IMR authors will be invited to present their reports to the SAR Panel. This will provide an opportunity for IMR authors to elaborate on and explain their findings, and give the SAR Panel the opportunity to identify key themes and learning to be considered for action across the partnership. Any additional action points identified by the SAR Panel will be discussed with the agency concerned and may be included in the SAR Overview Report

14.11.11 IMR authors should;

- Have received relevant training or have suitable experience in order to be able to complete the IMR to a suitable level
- Have access to supervision or peer challenge for the review
- Include information describing what happened, commenting on the quality of practice whilst also providing explanations for why it happened
- Be able to analyse the information gathered in their report showing clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice

14.12 SAR Overview Report

14.12.1 An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced.

14.12.2 The SAR overview report should not contain direct quotes from the collated IMRs. Instead it should draw out themes within the context of what was said rather than directly quoted.

14.12.2 An Executive Summary and learning brief may also be commissioned.

14.12.3 Final SAR 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.
- be clear and concise in order that it will be widely read.
- 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 as appropriate.

14.12.4 The final report will be published on the WSAB website, unless this would cause distress or harm to the adult and/or their family.

14.12.5 Draft reports should be shared with and explained to the adult and/or family to ensure that any queries or disagreements are discussed. Following this, the draft report will be reviewed by the SAR Panel and amended, if required, before submission to WSAB. The adult and/or family need to be informed of the timing and content of information which will be published, especially if there is media interest.

14.12.6 The SAR Overview Report will be presented to the Subgroup for sign off.

14.12.7 If a dispute arises between the Subgroup and the Chair of the Panel regarding the process, findings or report and resolution cannot be reached, this should be escalated to the Independent Chair of the Board.

14.12.8 When the Subgroup has signed off the report, the findings and learning areas will be presented to the WSAB. The subgroup will agree whether the Chair of the Panel should support this presentation. This may be required to ensure that the relevant information is provided to WSAB in complex reviews. The Board is responsible for agreeing the multi-agency recommendations.

SAR Protocol Flowchart – Carrying out a SAR

Commissioning of SAR (Stage 6)
Weeks 1-3

- Tender goes out for an independent Chair/Reviewer
- Contract letter sent once agreed
- Independent Chair/Reviewer identified and informed of the details of the SAR, required methodology
- Independent Chair/Reviewer produces the ToR to be presented to the CR Subgroup

SAR Commences (Stage 7)
Weeks 4-19

- SAR7 sent to identified agencies by WSAB Administrator requesting Panel member and Individual Management Review (IMR) Author nominations
- Family contacted and visited
- IMR Template and ToR sent to identified Panel member and IMR Author nominations by WSAB Administrator
- Panel and authors briefing takes place explaining the process
- IMR reports returned to WSAB Administrator and distributed to Panel members for review
- Panel and Independent Chair/Reviewer meet to analyse reports and identify any discrepancies. Additional information may be requested from authors
- Independent Chair/Reviewer produces first draft report and meets with Panel to review
- Practitioner Event takes place
- Independent Chair/Reviewer produces second draft report and meets with Panel to review
- Practitioner recall event takes place [depending on methodology used]
- Update on single agency action plans feedback to author to be included in report
- Independent Chair/Reviewer produces third draft report and circulates to Panel for comments

Finalising of Report (Stage 8)
Weeks 20-24

- Amended Daft Report shared with individual/family and feedback considered within report
- Draft Report is presented to CR Subgroup by Independent Chair/Reviewer and feedback considered with report
- Report presented to WSAB and feedback considered within report
- Any amends shared with Panel members
- Report shared with COMMS Chair in preparation of publishing
- Report finalised

Publication and Action Plans (Stage 9)
Weeks 24 – onwards

- Publishing process begins
- Subgroup Chairs meet to agree action plan
- Letter sent to individual/family from Chair advising of publication date
- Action plan begins (see subgroups SAR flowcharts)
- WSAB Administrator monitors and feeds back to CR Subgroup in relation to actions as appropriate

SAR Protocol Flowchart – Carrying out a Multi Agency Case File Audit (MACFA)

Commissioning of SAR (Stage 6)
Weeks 1 - 3

- Tender goes out for a SAR Chair/Reviewer
- Contract letter sent once agreed
- SAR Chair identified and informed of the details of the SAR, required methodology
- SAR Chair refines the ToR to be presented to the CR Subgroup
- WSAB Administrator sends SAR 7a and draft SAR 8a to agencies identified with a response deadline of 10 working days
- Adult and/or family contacted and visited
- Meetings booked by WSAB Administrator as per SAR 8a timescales

SAR Commences (Stage 7)
Weeks 4 - 19

- SAR 3b, SAR 8a and SAR 9a sent to identified MACFA author nominations by WSAB Administrator
- Author briefing takes place explaining the process
- MACFA reports returned to WSAB Administrator and distributed to SAR author for review
- SAR and MACFA authors meet to analyse reports and identify any discrepancies. Additional information may be requested from authors
- SAR author produces first draft report. WSAB Administrator distributes to MACFA authors for comments
- Update on single agency action plans feedback to author to be included in report
- SAR Chair produces second draft report and meets with MACFA Authors

Finalising of Reports (Stage 8)
Weeks 20 - 24

- Report shared with individual/family and feedback considered within report
- Report is presented to CR Subgroup by SAR Author/Chair and feedback considered within report
- Report shared with Communications Subgroup Chair in preparation for publishing
- Report presented to WSAB and feedback considered within report
- Any amendments shared with Panel members
- Report finalised. WSAB Administrator to share with :
  - CR Subgroup
  - Panel members
  - Individual/family
  - Other Subgroup Chairs

- WSAB Administrator sends out and collates evaluations to all involved in the SAR

- The WSAB liaison with the individual/family visits to discuss the report and next steps

Publication and Action Plans (Stage 9)
Weeks 24 - onwards

- Publishing process begins if appropriate. Once publishing date is agreed with Subgroup Chair, WSAB Administrator advises :
  - Subgroup Chairs
  - Board Manager
  - WSAB Chair
  - Involved agencies
  - Individual/family
  - SAR Chair

- Subgroup Chairs meet to agree Multi-Agency Action Plan (MAAP) with SAR author. This is then shared with the WSAB Chair
- Letter is sent to individual/family from WSAB Chair advising of publication date if appropriate
- Action plan begins (see subgroups SAR flowcharts)
- WSAB Administrator monitors and feeds back to CR Subgroup in relation to actions as appropriate

14.13. Action Plan

14.13.1 The Chair will be asked to lead on the development of the multiagency action plan in response to the recommendations. The Administrator will set up a meeting with subgroup Chairs to start the process. Consideration should also be given to involving the Panel members, particularly any specific experts, as they will have overall insight having participated in the SAR. Where leadership on an action is unclear, this can be referred to the Board Chair.

14.13.2 The multi-agency SMART action plan will be completed on SAR10 and distributed to the relevant subgroup Chairs, and others, to advise that an update on progress and evidence of the impact of learning will be requested on a quarterly basis to inform the quarterly report to WSAB.

14.13.3 Individual agencies will also produce their own internal action plans as part of the IMR process if required. Single agency action plans should be updated at the conclusion of the process, as more information will be available than at the time the IMR was written.

14.13.4 WSAB members are responsible for ensuring all actions from their own and the multi-agency action plan are completed, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies.

14.13.5 The Subgroup will co-ordinate and monitor progress against the action plan. The Administrator will write to individual agencies at the conclusion of the SAR process to request assurance of progress against the agency action plan and advising that an update will be requested on a quarterly basis to request assurance from the agency on progress against the action plan, and to provide evidence of the impact of learning.
An update will be provided in the quarterly report to WSAB. Any failure to complete actions will be escalated to the Board Chair.

14.13.6 Correspondence to and from respective agencies in respect of action plans will be shared with the Case Review Group to ensure co-ordination of responses and an awareness to members prior to further escalation.

14.13.7 The Subgroup will ensure that other WSAB Subgroups are made aware of relevant themes and issues as appropriate. The WSAB Learning Development and Practice Subgroup may be asked to arrange a learning event(s) if required to disseminate: the findings, areas of good practice, areas for improvement and lessons learned from the SAR.

14.13.8 It should be noted by all agencies that the adult/family will be updated on the outcome of the actions identified in the SAR by the Chair of the CR Sub Group.

14.14 Publication

14.14.1 WSAB is required to publish the Terms of Reference of all SARs.

14.14.2 The WSAB Annual Report will detail the findings of any SARs and subsequent action.

14.14.3 The WSAB will share with CQC any SAR that involves a regulated service (or one that should have been regulated).

14.14.4 The Subgroup will make a recommendation to WSAB on the publication of the SAR Overview Report. The report will be published unless it is considered that to do so would cause harm to the adult and/or family or would breech any duty of confidentiality. Reports should be written in order to minimise this.

14.14.5 Any decision regarding publication must consider the need to demonstrate openness, transparency and candour and support the national sharing of lessons.

14.15 Evaluation

14.15.1 At the end of a SAR the Chair and involved agencies will be asked to complete an evaluation form SAR11. This will enable to the Subgroup to develop the SAR process based on the feedback received.

15. Governance and timescales

15.1 SARs are resource-intensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

15.2 All SARs will be conducted through the Case Review Subgroup. The Subgroup is accountable to WSAB.

15.3 The Chair of the Subgroup will ensure the Chair of the Board and Director of Adult Services are informed of any SAR referrals, significant developments and progress of reviews. WSAB will be periodically briefed on the progress of each review and completion of action plans.

15.4 WSAB will aim to complete all SARs within eight months. This allows time for meaningful discussions with adult/family and consultation with specialist user groups eg BILD/Mencap etc and appropriate services regarding actions and ensuring they are SMART. The Director of Adult Services will be informed when it is identified that a SAR will not be completed within the target timescales.

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15.5 At the end of the SAR, the findings and proposed multi-agency recommendations will be presented to WSAB.

16. Data protection

16.1 Worcestershire County Council is the data controller for material that the WSAB creates. Individual agencies act as data controllers for their own material submitted as part of the SAR process.

16.2 The Administrator will agree the secure transmission of information with all agencies. This will be via secure or encrypted email.

16.3 Individual agencies, as data controllers, are responsible for the secure transmission of information.

16.4 WSAB will comply with data protection legislation including the General Data Protection Regulation (GDPR) 2016/679 and the Data Protection Act 2018 (DPA) when compiling or publishing the report, and will comply also with any other restrictions on publication of information, such as court orders.

16.5 This Safeguarding Adults Review Protocol needs to be viewed alongside WSAB **Information Sharing Protocol** which has been put in place in line with Section 45 of The Care Act (2014), Supply of Information, and be fully compliant in those circumstances where information is required from other persons to enable WSAB to exercise its functions.

16.6 All reports and documentation relating to the SAR are confidential and must be treated as such by all parties involved in the SAR. No items should be shared without prior consent from the SAR Independent Chair/Reviewer or the Case Review Chair.

17. Annual reporting

17.1 All SARs conducted within the year will be referenced within WSAB Annual Report along with relevant service improvements.

17.2 Information from SARs will also be published on WSAB public access web pages. WSAB will retain discretion over the content and timing of the publication, taking into account any mitigating factors such as ongoing criminal investigations.

18. Embedding learning

18.1 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.

18.2 All Safeguarding Adults Review action plans will have a specific action setting out how learning will be disseminated and embedded.

18.3 Learning from Safeguarding Adults Reviews will be disseminated in the following ways:

- Through regular Learning from Practice Events
- At post-review learning dissemination workshops
- By publication on WSAB Website
- By individual agencies taking responsibility to share learning internally.

19. Media Reporting and enquiries

19.1 WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB's approval.

19.2 During the SAR process any enquiries from the press in relation to the SAR are to be passed to the WSAB Coordinator.

19.3 The reactive press statement process for SARs is as follows;

1. General enquiry comes into WCC press office. Ideally this would be direct to WSAB but it is likely for press to come via WCC until the independence of WSAB is better publicised.
2. WCC redirects to WSAB Coordinator/Manager, defaulting to Communications Subgroup Chair or Vice Chair if neither is available.
3. WSAB Coordinator/Manager refers to Communications Subgroup Chair or Vice Chair with additional information supplied by WSAB Coordinator/Manager. The CR Chair is informed.
4. A press statement is approved by the WSAB Chair and CR Chair, defaulting to Communications Subgroup Chair or other Strategic Partner and CR Vice Chair, if not available.
5. The approved statement is released from Communications Subgroup Chair or Vice Chair to all relevant organisations, defaulting to WSAB Coordinator/Manager if not available.

20. Toolkit and Checklist

20.1 A Toolkit and Checklist have been put together to assist those involved in the process to carry out their duties as follows:

SAR 1 **Referral Form** **-** to be used by those making a referral for a case to be considered for a Safeguarding Adults Review.

SAR 2 **Scoping Document** - used to gather initial information from all agencies involved in a referral that is being considered for a Safeguarding Adult Review. This assists the Case Review Subgroup to make an informed recommendation for cases that do not appear straight forward. It also provides an audit trail of how informed the Case Review Subgroup were whilst making recommendations for a case to be reviewed or not reviewed.

SAR 3a **Family and Friends Guidance Information** - information for the adult, family, carers and friends explaining the process.

SAR3b **Agencies Involved SAR Guidance Information** - information for agencies requested by WSAB to be involved explaining the process.

SAR 4 **Scoping letter to agency** – letter to be sent with SAR2 and SAR3B when an organisation is not familiar with the process.

SAR 6 **Letter to SAR referrer to inform of CR decision**

SAR 7 **Letter to request Panel membership and IMR Author** – requesting the presence of an individual from an organisation on the Panel and, where required, an IMR author.

SAR 7a **Letter to request MACFA Author** – requesting an individual from the organisation to produce a MACFA

SAR 8 **Terms of Reference** – document which sets out the scope, timeframe and areas to be covered in the IMR.

SAR 8a **Terms of Reference** – document which sets out the scope, timeframe and areas to be covered in the MACFA.

SAR 9 **IMR** - Independent Management Review which evidences self-scrutiny by involved agencies. Guidance, Template report and checklist provided for agencies participating in the Safeguarding Adults Review.

SAR 9a **MACFA** – Multi Agency Case File Audit which evidences self-scrutiny by involved agencies. Guidance, Template report and checklist provided for agencies participating in the Safeguarding Adults Review.

SAR 10 **Multi-Agency Action Plan** – Actions derived from the recommendations in the authors report.

SAR 11 **Evaluation** – provides information from professionals involved in the SAR to help to improve the process.