A group of people with colorful circles

Description automatically generated

**Safeguarding Adult**

**Review Protocol**

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| --- | --- |
| Author | Safeguarding Adults Board (Business Unit) |
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This protocol will assist professionals to decide when to refer a case for consideration as a Safeguarding Adult Review (SAR), as well as providing guidance on the SAR Process.

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**1. Introduction**

1.1 The Care Act 2014 placed a statutory duty on Safeguarding Adults Boards (SABs) to undertake Safeguarding Adult Reviews (SARs).

[https://www.gov.uk/government/publications/care-act-statutory-guidance/care-](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

[and-support-statutory-guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

1.2 The SAR protocol has been developed by the South Tyneside Safeguarding Adults Board (SAB) and is part of the South Tyneside Safeguarding Adult procedures.

[http://www.southtynesidesafeguardingappp.co.uk/](http://hybrid-web.global.blackspider.com/urlwrap/?q=AXicVc27DcIwFEbhH7EBg9yEgCJEhVIioKGju0pMYuHYxk9lL0omYASmIS31-aSzWOLzBuQXcGoq6468SzSyVK3RwRlFrRmRmvXudD3fyk1dVVscuX1GoaQWdDGK9cGbGIYwaeFlJ6g3ieIDQwh2XxQ5Z_rrnu-ij-w6qXu21s6HmRcAVi_gBxfRMf0&Z)

1.3 The protocol will assist people and professionals to decide when to refer a case for consideration as a SAR, as well as providing guidance about the SAR process itself.

**2. Purpose**

2.1 The purpose of having a SAR is not to reinvestigate or to apportion blame, it is to:

* Establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults
* Review the effectiveness of procedures
* Inform and improve local inter-agency practice
* Improve practice by acting on learning
* Highlight good practice

2.2 SARs are not disciplinary proceedings and should be conducted in a manner which facilitates learning and appropriate arrangements must be made to support staff.

2.3 SARs are not enquiries into why an adult has died (or been significantly injured), or who is culpable. These are matters for criminal courts and coroner’s courts.

2.4 Where there is cross over with another non-statutory review process such as LeDeR, a statutory review will ordinarily take precedence; in practice this may involve ceasing the non-statutory process and commissioning the SAR.  In these circumstances to reduce potential for duplication for families and staff, the Practice Evaluation and Learning Subgroup / Executive Board should consider work that has been completed in the non-statutory review and whether:

* information from the non-statutory review should be incorporated into the SAR
* whether the non-statutory review is so advanced that the panel consider adding additional information/components to this to form a SAR
* whether a new SAR process should be initiated alongside the non-statutory review

**3. Statutory Duty Under Section 44 Care Act 2014**

3.1 There are 3 broad circumstances under which the Care Act 2014 (Section 44) considers a SAR may take place. The guidance makes a distinction between those circumstances where the Statutory Safeguarding Partners are required to consider cases and arrange a SAR, where appropriate.

3.2 The Statutory Safeguarding Partners must arrange for 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 it meets any of the following criteria:

1. The adult has died, and the Statutory Safeguarding Partners know or suspect the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died) and there is reasonable cause for concern about how the Safeguarding Partners, members of the STSor other persons with relevant functions worked together to safeguard the adult.
2. The adult is still alive, and the Statutory Safeguarding Partners know or suspect the adult has experienced serious abuse or neglect and there is reasonable cause for concern about how the Safeguarding Partners, members of the STSAB or other persons with relevant functions worked together to safeguard the adult.

3.3 The Statutory Safeguarding Partners may also arrange for 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).

3.4 SARs may also be used to explore examples of good practice, where this is likely to identify lessons which can be applied to future cases.

3.5 Each member of the STSAB 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.

**4. Safeguarding Adult Review Criteria**

4.1 The first criterion for determining whether a SAR should be conducted is in establishing whether the adult was in need of care and support services (whether or not the local authority was meeting any of those needs).

4.2 In considering whether an adult has needs for care and support, local authorities must consider whether:

* the adult’s needs arise from or are related to a physical or mental impairment or illness
* as a result of the adult’s needs, the adult is unable to achieve two or more of the specified outcomes (which are described in the Care Act 2014 guidance sections 6.105 to 6.112):

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506202/23902777_Care_Act_Book.pdf>

* as a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult’s wellbeing

4.3 Significant impact is not defined and should be understood to have its everyday meaning.

4.4 The second criterion to be met is establishing a cause for concern about how the South Tyneside Adults Board, its member organisations, or other persons with relevant functions, worked together to safeguard the adult. A particular emphasis is the extent they could have worked more effectively to protect the adult from the resultant outcome and therefore the potential for learning.

4.5 The third criterion involves an examination of the link between the death (or other outcome) and suspected abuse or neglect.

4.6 In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm, or has reduced capacity or quality of life as a result of the abuse or neglect.

**5. The Relationship Between Section 42 Enquiries and Section 44 Safeguarding Adults Reviews**

5.1 There will be occasions where a safeguarding enquiry may be required when an individual has died, however the purpose and title of these meetings will need to be considered carefully.

5.2 Section 42 of the Care Act 2014 places a duty on the Local Authority to make enquiries when it has reasonable cause to suspect an adult in its area has care and support needs, is being abused or neglected (or is at risk of being) and is unable to protect themselves because of their care and support needs. The purpose of Section 42 enquiries is to enable the authority to decide what action needs to be taken to protect the person. It therefore does not apply to the situation where someone has died and may have been abused or neglected before that. Section 44 of the Act provides for Safeguarding Adult Reviews to be carried out after someone has died, if the Statutory Safeguarding Partners know or suspect the death resulted from abuse or neglect, and there is reasonable cause for concern about how agencies or other persons with relevant functions worked together to safeguard the adult.

5.3 Section 42 enquiries are those which are undertaken when an adult, with care and support needs, has been identified as suffering or being at risk of abuse and neglect. As a matter of law, an enquiry under Section 42 cannot be undertaken in relation to a person who is deceased. Where someone’s death is suspected to be the result of abuse or neglect, a referral should be made to the South Tyneside Safeguarding Executive, the Statutory Safeguarding Partners will then consider whether the criteria for a SAR are met under Section 44.

5.4 If the circumstances of the death suggest there are reasons to be concerned about risk to other adults, Section 42 enquiries may need to be made to decide whether action needs to be taken to protect them.

5.5 For further information around Section 42 enquiries when a person has died during the enquiry process, please see Appendix 6, Adult Death Process Flowchart.

5.6 The Board may also arrange for a SAR in any other situation which involves an adult, in its area, with needs for care and support, for example multiple deaths of a similar presentation, such as self-neglect etc.

5.7 If the SAR criteria are not met but the Board feels there are lessons to be learnt an alternative non-statutory learning review may be undertaken.

**6. Procedure for Making a Referral for a Safeguarding Adult Review**

6.1 The Board is the only body that can undertake a SAR.

6.2 Any professional or person can make a referral for a SAR.

6.3 Staff will usually find it helpful to discuss their concerns with their organisation’s Safeguarding Lead prior to making a referral, using the consideration request for a SAR from (Appendix 2). Friends relatives and other parties may wish to discuss a referral with the STSAB Business Manager.

6.4 Referrals can be made via:

**Secure Email:** [STSCAP@southtyneside.gov.uk](mailto:STSCAP@southtyneside.gov.uk)

**In Writing:** South Tyneside Safeguarding Adults Board 38 Laygate Place

South Shields

Tyne & Wear

NE33 5RT

6.5 Discussions regarding the appropriateness of referring a case are welcomed by the STSAB Business Manager, telephone 0191 424 6513.

**7. Procedure for Undertaking a Safeguarding Adult Review**

7.1 Once a consideration request for a SAR has been received following actions will be taken:

**Immediate:** The STSAB Business Unit will circulate a secure email to all agencies on the Practice Evaluation and Learning (PEL) subgroup, with the name, address and date of birth of the subject asking for confirmation of whether they are known to the agency, and whether the subject is subject to any other form of formal enquiry, for example complaint procedures, significant incident review etc.

**Within 2 working days:** Agencies will respond to the request for confirmation the subject is known to their agency.

**Within 3 working days:** A basic report template will be sent to involved agencies with a request to return within **10 working days**

**Within 13 working days:** Agencies will return their template within **10 working days** of the above request

7.2 The Chair of the PEL subgroup, supported by the Board Business Manager, will discuss with members of the subgroup to consider whether the criteria are met. This will be informed on the initial information received from key agencies involved with the case. The subgroup will agree the recommendation to be made to the Independent Chair of the Safeguarding Adults Board.

7.3 The Independent Chair of the Safeguarding Adults Board is responsible for deciding whether to undertake a review or not, based on the recommendations of the Practice Evaluation and Learning subgroup.

7.4 The methodology for undertaking a SAR will be discussed and agreed by the Practice Evaluation and Learning (PEL) subgroup and the Safeguarding Adults Board.

7.5 The Board Business Manager or Chair of the PEL subgroup will inform the referrer in writing of the decision. If the decision is to undertake a SAR, the Board will make arrangements to notify the individual, their family or carers (where appropriate), partner agencies of the Board and the Care Quality Commission (regulator of health and social care services) if registered services are involved.

7.6 The SAR process is illustrated in Appendix 1.

**8. Interface with Other Proceedings or Investigations**

8.1 It may be necessary to consider whether the case meets the criteria for other multi-agency reviews.

8.2 The Board acknowledges that the following are statutory:

* Child Safeguarding Practice Reviews

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf>

* Domestic Homicide Reviews <https://www.gov.uk/government/collections/domestic-homicide-review>
* MAPPA Serious Case Reviews <https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf>
* Mental Health Homicide Reviews <https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/>
* Serious Incidents [https://www.england.nhs.uk/patientsafety/wp- content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf](https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf)
* The Learning Disability Mortality Review (LeDeR programme)

https://leder.nhs.uk/

8.3 There may be criminal or coronial investigations running concurrently with the SAR. Steps need to be taken to ensure the adult is safe, and any proposals for review must ensure the SAR does not prejudice criminal or judicial proceedings.

8.4 In some cases, criminal proceedings may follow the death or serious injury of an adult. The PEL subgroup Chair should discuss how the review process should take account of such proceedings with the relevant criminal justice agencies (such as the police and the Crown Prosecution Service at an early stage). Consideration should be given to, for example, effects on timing, the way in which the review is conducted (including any interviews of relevant personnel), what the potential impact on criminal investigations is and who should contribute at what stage. Careful consideration should also be given to disclosure of material under CPIA, (Criminal Procedure and Investigation Act 1985) from any SAR and partners within the SAR. Work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings.

8.5 It may also be necessary to delay the publishing of an overview report until the conclusion of any criminal trial. Individual agencies can however progress with implementing the learning from the review.

8.6 It is also acknowledged that all agencies will have their own internal or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these and any opportunities to prevent duplication will be encouraged.

8.7 In some cases, dependent on the specific issues in the case, internal investigation reports may provide adequate information to address the agreed terms of reference for the SAR; or it may be that additional reports are required to address any outstanding areas. Careful planning and communication is required to make the most effective use of resources and avoid duplication.

8.8 SARs are not part of any disciplinary process. However, should information emerge during the SAR that may indicate that disciplinary action should be taken; the agencies concerned should deal with such issues in accordance with their own procedures. If clarification is needed in respect of Person / People in a Position of Trust PiPOT, contact should be made with the **South Tyneside PIPOT Lead by emailing** [safeguardingadults@southtyneside.gov.uk](mailto:safeguardingadults@southtyneside.gov.uk) **.** **If disciplinary matters are in progress at the commencement of the SAR these should be notified to the Business Manager.**

**9. Methodology**

9.1 SARs can be conducted in a variety of ways. The Board will endorse the approach best suited to the circumstances of each individual case, and the Practice Evaluation and Learning subgroup will decide on the most appropriate method.

**10. Governance**

10.1 SARs are overseen by the Board, which is a multi-agency partnership with senior management representation from all the key agencies. The Board is responsible for ensuring that effective systems are in place for the completion of SARs, including:

* decision making in respect of undertaking reviews,
* formally accepting reports, and
* agreeing sign off of the report for publication

10.2 Responsibility for the management of SARs is delegated to the PEL subgroup. This group is responsible for the effectiveness of the SAR process to ensure timely completion of reviews. The Practice Evaluation and Learning subgroup will keep the Independent Chair and Board updated and make recommendations as required.

10.3 SARs will be presented to the Board on completion.

10.4 Involved organisations will be provided with copies of reports for comments on factual accuracy prior to the final draft.

10.5 All involved agencies will be asked to participate in identifying solutions to any recommendations of the review to support improvements in practice.

**11. Timescales**

11.1 SARs must be completed in a timely manner. See Appendix 1a/1b

11.2 The recommendations from the Practice Evaluation and Learning subgroup should be provided in writing within 5 working days of the meeting to the Independent Chair of the Safeguarding Adults Board.

11.3 The Independent Chair will make a decision on whether there should be a review as soon as possible and PEL sub group members will be updated accordingly.

11.4 Once the decision to undertake a SAR has been made it will be communicated to Partners at the next scheduled PEL subgroup meeting. it is good practice for a SAR to be completed within six months, wherever possible.

11.5 It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues which emerge from the review and need to be considered without delay should be brought to the attention of the Board.

**12. Responsibilities to the Individual(s) and Family or Carers**

12.1 It is important that consideration is given to the best means of notifying the individual(s) (where possible), and their relatives and carers (where appropriate) that a review is being undertaken.

12.2 Individual(s) will be notified that the review will look at records and notes held by public bodies, including adult social care and health providers.

12.3 Where appropriate, the Board will make arrangements for the individual(s) and / or their family and carers to participate in the SAR. Their consent is not required for the review to go ahead. Please see Appendix 5

12.4 Individual(s) and/or their families and carers should be kept updated at key stages of the review, for example at the appointment of a reviewer, when the first draft of the review ready and prior to publication of the report. The timescale and feedback to the individual(s) and/or their families will be set out in the scope/terms of reference for the SAR.

**13. Responsibilities to Staff**

13.1 The staff directly involved in the care and support of individuals subject to a SAR should be notified of the decision to undertake a SAR, and there is an expectation that support will be provided to them by their agency. The process and their involvement should be fully explained.

13.2 At the end of the process staff will be invited to share their experiences and give feedback on the process.

**14. The Report**

14.1 The PEL subgroup will be responsible for appointing a Lead Reviewer to determine the Terms of Reference and understanding the SAR. The Lead Reviewer should be an experienced individual who has no direct involvement with the case.

14.2 In compiling the SAR report, it should:

* provide a sound analysis of what should have happened /what did happen
* contain findings or recommendations of practice value to organisations and professionals
* be written in plain English

14.3 Where appropriate, arrangements will be made to share the report and its findings with the individual(s), and / or their family and carers.

14.4 The final report will be signed off by the South Tyneside Safeguarding Adults Board.

**15. Media, Communication and Publication**

15.1 The PEL subgroup Chair, in consultation with the Safeguarding Adults Board, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

15.2 Since Adult Social Care is the lead agency, media and communication issues will usually be coordinated by the Council’s Communications Team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.

15.3 All SAR reports will be considered for publication on the website of the Board. In the case of publication, Safeguarding Adults Board will release a statement where appropriate. If publication is agreed the report will remain on the STSAB website for a minimum of one year.

**16. Implementation and Evaluation**

16.1 The real value of the completion of a SAR is to ensure that the relevant lessons have been learnt and that professional multi-agency safeguarding is improved, in order to prevent the issues in question happening again.

16.2 The PEL subgroup group will consider the recommendations from the report and agree an action plan.

16.3 The PEL subgroup will be responsible for ensuring the implementation of the action plan, monitoring the progress made and making links with relevant subgroups of the Board as required.

16.4 Following the completion of a SAR, learning will be cascaded through single and multi-agency learning and development opportunities and quarterly safeguarding updates from the STSAB Business Manager.

16.5 Progress Events will be held across the year with relevant organisations and partners to evaluate the actions, learning and impact from any SAR’s/Local Learning within their organisation.

**17. Review**

17.1 There will be a formal annual review of this protocol to take account of developments and new legislative requirements.

**INITIAL NOTIFICATION RECEIVED BY SAFEGUARDING ADULTS BOARD**

STSAB Business unit to send out basic reporting template to involved agencies with a request to return within 10 working days

Practice Evaluation and Learning subgroup meet to consider the case and make a recommendation to the Independent Chair of the Safeguarding Adults Board on whether the case meets the SAR Criteria

**SAFEGUARDING ADULT REVIEW PROCESS**

**(Stage One)**

**Immediate**

STSAB Business Unit to send email to all partner agencies with basic details (name, address, and date of birth) to ask if the subject is known to their agency)

**Within 2 Working Days**

**CASE MEETS THE SAR CRITERIA**

**Within 15 Working Days**

**Within 3 Working Days**

All agencies to respond with confirmation of whether the adult is known to their agency and to confirm whether the case is subject to other ongoing enquiries, for example significant enquiry, complaints etc

STSAB Business Unit will collate agency responses into a multi-agency chronology

**Next scheduled meeting**

Referrer informed and given rationale

Case closed to Practice Evaluation and Learning subgroup

**No**

**No – but key areas of learning are identified**

**Yes**

Independent Chair informed of the recommendations of the Practice Evaluation and Learning subgroup

Independent Chair makes the final decision and PEL subgroup members will be updated accordingly

Referrer informed Task and Finish Group from within Practice Evaluation and Learning subgroup has been set up to identify and disseminate the learning

**APPENDIX 1A**

Draft Overview Report, with recommendations submitted to the STSAB for:

* Amendments/approval
* Development of Action Plan
* Development of Communications Plan

Note: If timescales allow the draft overview report will be presented to the next available Safeguarding Adults Board meeting, if not an Extraordinary Meeting of the Adults Board will be convened

**Independent Chair of the South Tyneside Safeguarding Adults Board approves Safeguarding Adult Review**

Practice Evaluation and Learning subgroup appoints a Lead Reviewer with sufficient independence to lead the SAR

Individual / Family informed of SAR Process and given the opportunity to provide their views

**Practice Evaluation and Learning subgroup to:**

* Consider dissemination of the Overview Report findings and recommendations
* Agree Learning Events
* Ensure the learning from the SAR is included within the relevant multi-agency training programmes
* Ensure the STSAB Annual Report contains required information on SAR
* Build relevant objectives into Strategic Plan

**Within 20 Working Days**

Terms of reference, methodology and timeline agreed by Lead Reviewer and Practice Evaluation and Learning subgroup

**Within 6 Months**

Final Overview Report shared with the individual/family prior to publication

Report published on STSAB Website for a minimum of one year

**SAFEGUARDING ADULT REVIEW PROCESS**

**(Stage Two)**

**APPENDIX 1B**

|  |
| --- |
| **CONSIDERATION REQUEST FOR SAFEGUARDING ADULTS REVIEW** |

#### A **Safeguarding Adults Review (SAR)** is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adult cases, where an adult in vulnerable circumstances has died or been seriously injured, and abuse or neglect has been suspected.  As a result of a detailed review, recommendations are made to change or improve practice and services.

**APPENDIX 2**

**The aim of the process is to learn lessons and make improvements, not to apportion blame to individual people or organisations.**

A SAR is about promoting effective learning and improvement to prevent future deaths or serious harm occurring again. It relies on a spirit of openness to learning about what went well, as well as what could be improved. The process is based on national guidelines and has been agreed by all agencies who are members of the South Tyneside Safeguarding Adults Board (STSAB).

|  |
| --- |
| **Criteria for a SAR:** the South Tyneside Safeguarding Adults Board (STSAB) must arrange a Safeguarding Adults Review when either of these criteria are met: |
| 1. An adult with care and support needs**\*** (whether or not those needs are met by the Local Authority) in the STSAB area has died as a result of abuse or neglect, whether known or suspected **and** there is concern that partner agencies could have worked together more effectively to protect the adult, ***or…*** |
| 1. An adult with care and support needs (whether or not those needs are met by the local authority) in the STSAB area has not died, but the STSAB knows or suspects the adult has experienced serious**\*\*** abuse or neglect **and** there is concern the partner agencies could have worked together more effectively to protect the individual, ***or…*** |
| 1. The STSAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice, ***or…*** |
| 1. The STSAB can also consider conducting a SAR into any incident(s) or case(s) involving adults(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review. |
| **\* Care and support needs** arise as a result of a physical or mental impairment and are focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation. |
| **\*\*** In the context of SARs, **something can be** **considered serious abuse or neglect where**, for example, the individual would have been likely to have died but for an intervention or has suffered permanent harm or had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. |
| **The submission of this form should not prevent immediate learning and action for any agency** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Date:** |  | | |
| **REFERRER’S DETAILS** | | | |
| **Name:** |  | **Organisation:** |  |
| **Role:** |  | **Telephone:** |  |
| **Email address:** |  | | |
| **AUTHORISED BY SENIOR MANAGER** | | | |
| **Name:** |  | **Role:** |  |
| **Email address:** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **DETAILS OF ADULT AT RISK OF ABUSE OR NEGLECT** | | | |
| **Full Name:** |  | | |
| **Any Known Aliases:** |  | | |
| **Date of birth:** |  | **Date of death:** |  |
| **Cause of Death:** | (If applicable) | | |
| **Gender:** |  | **Ethnicity:** |  |
| **Religion:** |  | **Disability:** |  |
| **Address:** |  | | |
| **Any Other Known Address(es):** |  | | |
| **GP name:** |  | **NHS number:** |  |
| **GP surgery:** |  | | |
| **Did this adult meet the Adult at Risk Criteria?** | No  Yes  If yes, what are the care and support needs you feel this adult may have had? | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY / NEXT OF KIN / ADVOCATE / REPRESENTATIVE** | | | |
| **Full Name:** |  | **Telephone Number:** |  |
| **Address:** |  | | |
| **OTHER MEMBERS OF THE ADULT CONCERNED HOUSEHOLD** | | | |
| **Name** | **Date of Birth** | **Address** | **Relationship to adult concerned** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Details of Alleged Perpetrator(s)** | | | |
| **Full Name:** |  | **Telephone Number:** |  |
| **Date of Birth:** |  | **Ethnicity:** |  |
| **Address:** |  | | |
| **Relationship with the adult concerned:** | (If applicable) | | |
|  | | | |
| **Full Name:** |  | **Telephone Number:** |  |
| **Date of Birth:** |  | **Ethnicity:** |  |
| **Address:** |  | | |
| **Relationship with the adult concerned:** | (If applicable) | | |
|  | | | |
| **Full Name:** |  | **Telephone Number:** |  |
| **Date of Birth:** |  | **Ethnicity:** |  |
| **Address:** |  | | |
| **Relationship with the adult concerned:** | (If applicable) | | |

|  |
| --- |
| **SUMMARY OF WHAT HAPPENED** |
| **Provide a brief summary of what happened** – the events and circumstances that led to this referral; include when and where the event happened, and in what context.  **Please do** use plain language that can be understood by those with no prior knowledge of your agency; give the meaning of any acronyms you use.  **Please do not** copy and paste extensive information from your agency’s records or case management systems. |
| (Enter text here) |
| **Please identify** the type(s) of abuse relating to this case (more than one may apply):  [Click here for guidance on types and indicators of abuse](https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse) |
| (Enter text here) |

|  |
| --- |
| **EXPLAIN HOW THE CASE MEETS THE CRITERIA FOR A SAR** |
| **Please refer to the criteria for a SAR on the first page** and explain in detail, how you feel this case meets the criteria for a Safeguarding Adults Review.  **Please do** respond fully to each separate criteria, using plain language, easily understood by those working outside of your agency.  **Please ensure** for criteria a) and b) that you clearly outline your concerns about how separate agencies worked together.  Further information can be found in the [Care and Support Statutory Guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance), Chapter 14, paragraphs 14.162 to 14.179. |
| 1. An adult with care and support needs has died as a result of abuse or neglect, whether known or suspected **and** there is concern that partner agencies could have worked together more effectively to protect the adult. |
| (Enter text here) |
| 1. The adult has not died but has experienced serious abuse or neglect**\****(see first page),* whether known or suspected **and** there is concern the partner agencies could have worked together more effectively to protect the individual. |
| (Enter text here) |
| 1. The STSAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice. |
| (Enter text here) |
| 1. The STSAB can also consider conducting a SAR into any incident(s) or case(s) involving adults at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review. |
| (Enter text here) |

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| **OTHER PROCESSES & AGENCIES INVOLVED** |
| **Are or were there any legal orders in place?** No  Yes |
| (If yes please identify what they were) |
| **Please provide details of any other processes** you know to be underway in relation to this case, eg. DHR, LeDeR, SI / RCA review, criminal investigation, coroner’s inquest.  No  Yes |
| (If yes please identify what they were) |
| **Please list any other agencies or services** you know to be involved in this case.  For example: social services, police, health services, fire and rescue, housing, probation services, ambulance, residential or domiciliary care, nursing homes. |
| (Enter text here – please include contact names and telephone numbers if known) |

**Please return this form to** [**STSCAP@southtyneside.gov.uk**](mailto:STSCAP@southtyneside.gov.uk) **within 48 hours of notification.**

**Letter requesting Information from Multi-agency partners**

**APPENDIX 3**

Dear Colleague

**URGENT: SAFEGUARDING ADULT REVIEW**

An incident has taken place that may require a Safeguarding Adult Review to be convened under the Care Act 2014:

**Name of adult concerned:** [insert name, address, DOB]

**Name of alleged perpetrator:** [insert name, address, DOB]

**Other household members:**  [insert name, address, DOB]

Please complete the information required in **Appendix 4** attached to this letter. This is required to identify which agencies should attend the Practice Evaluation and Learning subgroup meeting and which hold relevant information that would inform a Safeguarding Adult Review in the event of one being commissioned.

**Please secure records immediately by copying and/or restricting electronic access. To be completely clear, only staff who will be involved in the SAR process (should it proceed), should have access to the file from now on.**

Your completed template should then be forwarded to [STSCAP@southtyneside.gov.uk](mailto:STSCAP@southtyneside.gov.uk) from a suitably secure email **within 10 working days** of receiving this request. This information is only required in brief at present – i.e. we are not asking you to write a full review of your agency’s involvement at this stage. We are asking for this information in order to determine whether it is necessary to conduct a full Safeguarding Adult Review and if so which agencies need to be involved.

**In the event that the adult concerned has died please ensure any staff or volunteers who had contact with the person involved in the case are aware of the death and that they have access to appropriate support**.

A decision will be taken on whether to go ahead with a Safeguarding Adult Review. We will be in touch again following that decision.

Yours sincerely

Jackie Nolan

STSAB Business Manager

**MULTI- AGENCY INVOLVEMENT TEMPLATE**

**APPENDIX 4 4**

|  |
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| **Summary of Involvement:**  The information requested on this form will be for the purpose of deciding whether the criteria for holding a Safeguarding Adults Review have been met.  ***Notes:***   * This information is only required in brief at present – i.e. we are not asking you to write a full review of your agency’s involvement at this stage. We are asking for this information in order to determine whether it is necessary to conduct a full Safeguarding Adult Review and if so, which agencies need to be involved. * This template should be used as it is and information should not be ‘copied and pasted’ from other documents/recording systems. ***If the template is not completed appropriately, it will be returned.*** |

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| --- | --- | --- | --- |
| **Subject of the Report** | | | |
| **Name** | **D.O.B.** | **D.O.D** | **Address** |
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| --- | --- | --- | --- |
| **Other relevant family members (please add any additional information which supports this scoping exercise)** | | | |
| **Name** | **D.O.B.** | **Relationship to Subject** | **Address** |
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| **Brief Summary of Concerns** |
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| **Details of the Professional Completing the Form** |

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| --- | --- |
| **Name of Agency:** |  |
| **Name and Job Title of Lead Safeguarding Adults Professional:** |  |
| **Email:** |  |
| **Agency relationship with Adult:** |  |
| **Date when your involvement with the adult started:** |  |
| **Date when your involvement with the adult ceased:** |  |

|  |  |
| --- | --- |
| **Factual summary of agency involvement:**  Provide a brief factual and contextual summary of your agency’s involvement with the adult. Note the following key information:   * Significant events, attendance at appointment; * Involvement of other agencies/friends/family (with contact info where possible); * Changes in level of need/engagement with agencies and * Referrals of concerns, and how these were received by other agencies. | |
| **Date:** | **Summary of Involvement** |
| 00/00/0000 |  |
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| **Other known agencies working with the individual e.g. local voluntary services:** | |
| **Organisation:** | **Contact (if known):** |
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| **Details of any concerns about the adult/carer and the actions taken by the agency:** |
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| **I confirm that this is an accurate Summary of Involvement in the line with the South Tyneside Safeguarding Adults Review Protocol.**  **Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Notification to individual/family letter**

**APPENDIX 5**

Dear

**Re: Statutory Safeguarding Adults Review**

Firstly I wish to offer you and your family my sincere condolences following the sad passing of your [insert relationship to family member(s)], [name of subject(s)], and apologise for contacting you at such a difficult time.

Following a multi-agency review of the information relating to this case a number of agencies in South Tyneside will be taking part in a Safeguarding Adult Review of their involvement in the case in accordance with their duties under the Care Act 2014.

The purpose of such a review is to establish whether there are lessons to be learned from the way in which local professionals and organisations worked together, with a view to improving service responses and inter-agency working in future.

I would very much like you to contribute to the review and ask whether you would be willing to meet with me, at a time and place convenient for you, at an appropriate point in the process. This will be your opportunity to share your views on the way that agencies worked and the services that were provided.

If you would like to contribute to the review, or require any further information, please contact the South Tyneside Safeguarding Adults Board on 0191 424 6512 or by emailing [STSCAP@southtyneside.gov.uk](mailto:STSCAP@southtyneside.gov.uk) and the appropriate arrangements will be made.

Yours sincerely

Jackie Nolan

STSAB Business Manager

38 Laygate Place

South Shields

Tyne & Wear

NE33 5RT

Tel: 0191 424 6513

Email: [jacqueline.nolan@southtyneside.gov.uk](mailto:jacqueline.nolan@southtyneside.gov.uk)

**APPENDIX 6**



An adult with care and support needs dies during the safeguarding process (s42 enquiry)

The s42 enquiry should be concluded immediately

As a matter of law an enquiry under Section 42 cannot be undertaken in relation to a person who is deceased

**Are there concerns that the death may be lined to abuse or neglect?**

**Are there outstanding actions?**

Ensure one of these outcomes are considered within the Closure of Safeguarding documentation in LAS:

* Consider SAR
* Referral to Coroners
* Referral for Learning Review
* Referral to LA Commissioning/QM
* Referral to external partner process

The s42 enquiry should be closed down

The s42 enquiry should be closed with a **Safeguarding Adults Conclusion Meeting**.

The **Safeguarding Adults Conclusion Meeting** minutes should be attached as a document to the safeguarding episode, and a case note added

No

Yes

No

Yes

**Adult Death Process – Flowchart**