



OLDHAM ADULTS SAFEGUARDING BOARD

Safeguarding Adults Review Policy: Conducting SARs in Oldham under Section 44 of the Care Act 2014

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Foreword

The Department of Health and Social Care, Care Act Statutory Guidance states that in order to achieve the aims of safeguarding, it is important to *'support the development of a positive learning environment across partnerships and at all levels within them to help break down cultures that are risk-averse and seek to scapegoat or blame practitioners'*.

One of the core duties of a Safeguarding Adults Board (SAB) is to review cases, where an adult with needs for care and support has died and the death resulted from abuse and neglect or is alive and the SAB knows or suspects that they have experienced serious abuse or neglect.

Importantly, Safeguarding Adult Reviews are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be mandatory in legislation, there must be reasonable cause for concern about how the SAB, its members (or others with relevant functions) worked together to safeguard the adult.

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1. Introduction

1.1 Purpose of Policy

This policy outlines the process for the management of Safeguarding Adults Reviews (SARs) in Oldham under Section 44 of the Care Act 2014. This protocol has been developed to simplify and clarify the local process by:

- providing an overview of how to notify serious incidents which may be suitable for a SAR
- enabling a consistent approach to SAR decision making and practice
- demonstrating how local processes comply with legal requirements and best practice
- clarifying SAR timeliness in line with legislation and statutory guidance
- providing a resource to enable those involved in reviews to answer common questions
- clarifying local roles and responsibilities including the decision making and publication responsibilities of the SAB
- providing transparency about the review process
- supporting practical planning and preparation of reviews

1.2 Legislation and Statutory Guidance

Section 44 of The Care Act 2014 outlines the SAB's core duty to conduct SARs and can be found [here](#).

Statutory Guidance published by the Department of Health and Social Care in relation to SARs can be found [here](#).

2. Purpose of a SAR

The Statutory Guidance notes that the purpose of a SAR is to: *'promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account'*.

SARs are not disciplinary proceedings, and should be conducted in a manner, which facilitates learning, and appropriate arrangements must be made to support staff. SARs are not enquiries into why an adult has died (or has been significantly injured), or who is culpable. These are matters for criminal courts and Coroner's courts.

It should also be noted that the SAB are concerned with reviews of significant cases, some of which will become SARs and others may become reviews that will not meet the threshold but will be commissioned by the SAB when considered necessary. The learning and recommendations from all reviews will be treated in the same way as a formal SAR.

3. Safeguarding Principles

The Care Act 2014 states SARs should reflect the six safeguarding principles:

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent
- **Prevention** – It is better to take action before harm occurs
- **Proportionality** – The least intrusive response appropriate to the risk presented
- **Protection** – Support and representation for those in greatest need
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

- **Accountability** – Accountability and transparency in delivering safeguarding.

In the context of these principles the SAB will conduct SARs ensuring:

- leadership by individuals who are independent of the case under review and of the organisation whose actions are being reviewed.
- a culture of continuous learning and improvement, promoting the well-being and empowerment of adults, promoting good practice and focusing on opportunities to apply what works.
- a culture of transparency is created that identifies a flexible and proportionate environment for learning.
- a proportionate response that identifies timely action is taken to respond to the need for systematic or professional changes.
- involvement of professionals to contribute their perspective without fear of being blamed for actions they took in good faith.
- families are invited to contribute to the reviews, understanding how they are going to be involved.
- contribution to processes that explore the broad issues and learning in a wider multi-agency setting rather than limiting the potential to develop solutions to those agencies involved in the case.

4. SAR Criteria

The SAB **must** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if: there is reasonable cause for concern about how effectively the SAB, members of it or other persons with relevant functions, worked together to protect the adult, and either:

- the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)
or
- the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect

The SAB **can** also arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

See Appendix 1 for the 'OSAB Decision Flowchart: Reviews Under the Care Act 2014'.

5. Referral for a SAR

The SAB is the only body that can undertake a SAR.

Any professional can make a referral for a SAR if they believe the case meets the criteria for consideration. The Coroner, Members of Parliament and Elected Members of Oldham Borough Council can also make a referral for a SAR. Professionals will usually find it helpful to discuss their concerns with their agency's safeguarding lead prior to making a referral. The SAR referral should be made as soon as it is recognised the SAR criteria could be met. A referral can be made at any stage of a Safeguarding Enquiry, even if the enquiry remains ongoing. This referral does not replace Safeguarding Adult Enquiries, which would look at immediate safeguarding and protection for adults at risk. Discussions regarding the appropriateness of referring a case are welcomed by the SAB Manager.

See Appendix 2 for the 'OSAB SAR Referral Form'. Referral Forms should be emailed to OldhamSafeguardingAdultsBoard@oldham.gov.uk

6. Decision

6.1 Decision Process

Upon receipt of a referral, the SAB Coordinator will send an email to the referrer confirming receipt. The SAB Coordinator will also notify the SAB Independent Chair, Chair of the SAR Sub Group and the SAB Manager that the referral has been received.

The SAB Coordinator will circulate the SAR Referral and the Case Screening Report Template (See Appendix 3) to SAB partner agencies and request that agencies provide all relevant information. Screening Reports should be completed by managers who have not had operational responsibility for the case but understand the service. The SAB Coordinator will schedule an Extraordinary Meeting of the SAR Sub Group in order to screen the case. The screening must take place as soon as possible following the submission of agency information. This meeting requires a minimum of one representative from each of the Statutory Partners as defined in the Care Act: Local Authority, Clinical Commissioning Group and Police.

Having considered the SAR referral and the relevant agency information, the SAR Sub Group will be responsible for making a recommendation to the SAB Independent Chair about whether to commission a SAR or not. If the SAR Sub Group conclude that a SAR should be undertaken then consideration will be given to draft Terms of Reference, the methodology to be used, the scoping period, and the membership of the Review Panel. If the SAR Sub Group conclude that a SAR should not be undertaken, then consideration will be given to other types of reviews. If the SAR Sub Group conclude that additional information is required prior to making a recommendation, then the SAB Coordinator will coordinate the actions as agreed by the SAR Sub Group and collate and share all additional information with the SAR Sub Group. A further Extraordinary Meeting will be scheduled in order to reach a recommendation.

The SAR Decision Document (Appendix 4) will be completed by the SAB Coordinator in conjunction with the Chair of the SAR Sub Group. The SAB Independent Chair will notify the SAB Coordinator of their decision using this document. If the SAB Independent Chair disagrees with the recommendation a further Extraordinary Meeting of the SAR Sub Group will be arranged to discuss a response to the SAB Independent Chair.

The SAB Coordinator will share the SAB Independent Chair's decision with the referrer. If the referrer wishes to appeal against a decision not to carry out a SAR, the appeal should be put in writing to the SAB Independent Chair, who will, if necessary, discuss and review the decision with the referrer and the SAR Sub Group members who made the initial recommendation.

6.2 Decision Process Timeframe

Action	Timeframe	Approximate Working Day
Referral received.	As soon as is reasonable after case has been identified.	0
Confirmation of receipt of referral sent.	Within 1 working day of the referral being received.	1
SAR Referral and Screening Report Templates issued.		
Independent Chair, Chair of the SAR Sub Group and SAB Manager notified.		
Extraordinary Meeting of SAR Sub Group scheduled and invitations sent.		
Completed Screening Reports returned.	Within 10 working days of request being sent.	11
All Screening Reports combined and distributed to the members of the SAR Sub Group.	Usually 5 working days prior to the Extraordinary Meeting for Screening.	11-12
Referral screened at an Extraordinary Meeting of the SAR Sub Group.	Usually within 10 working days of the completed Screening Reports being returned.	16-20

SAR Sub Group recommendation sent to Independent Chair.	Within 5 working days of the Extraordinary Meeting of the SAR Sub Group.	21-25
Independent Chair decision received.	Within 10 working days of the Extraordinary Meeting of the SAR Sub Group.	26-30
Decision shared with the referrer and referrer informed of opportunity to appeal the decision if a review is not to be conducted.	Within 15 working days of the Extraordinary Meeting of the SAR Sub Group.	31-35

7. SAR Procedures

7.1 Good Practice

The Statutory Guidance states that *'the SAB should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings'*.

A SAR will be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard adults
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- makes use of relevant research and case evidence to inform the findings.

7.2 SAR Process

The SAB will aim to complete a SAR within six months of the decision being undertaken.

The SAB Coordinator will inform the SAR Sub Group, Coroner, lead member, Chief Executive and the statutory SAB members of the intention to commission a SAR. The SAB Coordinator will also share the decision with the individual and/or their family, friends or carers, as appropriate.

The SAB Manager, in conjunction with the Chair of the SAR Sub Group, and the SAB Coordinator will commission an Independent Author for the SAR (see section 9: Appointment and Role of the Independent Author). The Referral, Screening Reports and SAR Decision Document will be shared with the Independent Author. An initial Panel Meeting will be held to finalise the Terms of Reference, the methodology to be used and the scoping period. It will also be determined which types of report/summary partner agencies will provide. The Agency Report/Summary template will be approved by the Independent Author before being distributed.

The SAB Coordinator will ask representatives of SAB partner agencies to complete an Agency Report/Summary. Agency Reports/Summaries should be completed by managers who have not had operational responsibility for the case but understand the service. Agency representatives will inform the SAB Coordinator if a briefing session, offering guidance to complete the Agency Report/Summary, is required. This will be conducted either virtually or in person dependent on the number of agencies who require guidance. Once all Agency Reports/Summaries are received, the SAB Coordinator will combine chronologies into a single file and share this with the Independent Author and the members of the Review Panel.

The Independent Author will progress work to extract the learning. This part of the process will be facilitated by the SAB Coordinator and will be dependent on the methodology chosen. For instance, this may involve a one-day learning event, a series of Panel meetings, a desktop review or a multi-agency audit. This period will include the opportunity for the individual or their families to meet with the Independent Author.

A first draft of the Overview Report will be written by the Independent Author and shared with the Review Panel members for their feedback.

Review Panel members will discuss the issue of using the real name of the individual or a pseudonym in the Overview Report. Whilst the views of the individual and/or their family members will be taken into account, ultimately this is for the SAB to decide.

The final Panel meeting will include discussion about any Communication issues and decisions made about what information needs to be communicated and to who (see section 18: Media and Communications Strategy).

Amendments and subsequent drafts of the Overview Report will be shared with the Review Panel members before the final version including an Executive Summary is presented to the SAB for reflection on the review process, quality assurance and sign off as well as discussion concerning publication.

It will be the responsibility of the SAR Sub Group to identify and agree how practice challenges or recommendations from the Overview Report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

7.3 Process Timeframes

Action	Timeframe	Approximate Working Day	Month
Independent Chair decision received.	Within 5 working days of receiving the recommendation from the SAR Sub Group.	0	1
Decision shared with SAR Sub Group, Coroner, lead member, Chief Executive and the statutory SAB members.	Within 1 working day of the decision being received.	1	1
Decision shared with the individual, their family, friends or carers (as appropriate).	Within 5 working days of the decision being received.	5	1
Independent Author commissioned and sent the Referral, Screening Reports and SAR Decision Document.	Within 15 working days of the decision being received.	15	1
Initial Panel Meeting held.	Allowing sufficient notice for Panel Members and Independent Author.	20-25	2
Request for Agency Reports/Summaries to be completed sent (including deadline for Agencies to request a briefing session and a deadline for Report/Summary submission).	Once template approved by Independent Author.	21-27	2
Agency representatives request briefing session, if required.	Within 5 working days of the Request for Agency Reports/Summaries to be completed.	26-32	2
Briefing Session held, if required.	Allowing sufficient time for attendees to meet the Agency Report/Summary submission deadline.	27-33	2
Agency Reports/Summaries returned and shared with Independent Author and Panel members.	Within 15 working days of the Request for Agency Reports/Summaries to be completed.	36-42	2
Learning extracted, dependent on the methodology chosen. And first draft of the Overview Report shared with Panel members.	Following sharing of the Agency Reports/Summaries.	37-95	3

Amendments and subsequent drafts of the Overview Report shared with Panel members.		42-125	3-5
Final Overview Report and Executive Summary presented to the SAB for sign off.		130	6

8. Information Sharing and Retention

Section 44 of the Care Act 2014 states that *‘each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to identifying the lessons to be learnt from the case and applying those lessons to future cases’*. Section 45 of the Care Act 2014 outlines compliance in relation to supply of information and can be found [here](#).

Information received for the purpose of SARs must not be stored for longer than necessary and must not be used or shared in any way without the prior consent of the SAB members. SAB partner agencies and their representatives should be aware, as public bodies, that the information provided to the SAB can then be requested by the Crown Prosecution Service or by Her Majesty’s Coroner as part of ongoing investigations. Therefore, senior management oversight should be sought prior to information being submitted. Should a request for information be made by the Crown Prosecution Service or by Her Majesty’s Coroner then the relevant partner agencies will be notified by the SAB Business Unit.

9. Appointment and Role of the Independent Author

9.1 Required Skills and Expertise

The Independent Author should be an experienced individual who is not directly associated with any of the agencies involved in the SAR. Consideration should be given to the skills and expertise required to effectively lead a SAR including:

- Strong leadership and ability to motivate others
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- Collaborative problem-solving experience and knowledge of participative approaches
- Ability to find and evaluate best practice
- Good analytic skills and ability to manage quantitative and qualitative data
- Knowledge of safeguarding adults and an understanding of the complexity of the health and social care system
- Ability to write for a wide audience

9.2 Responsibilities

The Independent Author will be responsible for chairing Panel meetings, effectively leading and coordinating the Review Panel and for quality assurance of the final Overview Report based on the Agency Reports/Summaries and any further evidence deemed relevant.

The Independent Author will be responsible for the final decision on the suitability of the Terms of Reference, agreed with the Review Panel members at the initial Panel meeting. The Terms of Reference may, however, need to be revisited as the review progresses and as new information is identified; the Independent Author will agree any amendments with the Review Panel members.

The Independent Author will establish an agreed timetable of key dates in accordance with the required timescales of the review to include, for example, Panel meetings and learning events.

The Independent Author will be responsible for engagement with the individual and/or their family. This will be facilitated by the SAB Business Unit. The Independent Author will direct any media interest about the SAR to the SAB Business Unit who will respond following consultation with the Council Communications team/PR & Comms Sub Group, as appropriate. The Independent Author will ensure that regular updates are obtained regarding agencies providing services to meet the safeguarding or other needs of individuals who are subject of the SAR. The Independent Author will maintain contact with the lead personnel of all parallel reviews or investigation processes, to ensure that any coordination and joint commissioning arrangements are effective (see Section 12: Parallel Processes).

The Independent Author will produce a final Overview Report and Executive Summary, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency recommendations are succinct. The Independent Author will, as far as possible, ensure that the review process is a learning exercise in itself for all those involved in the case.

10. Involvement of Individuals, Family Members, Friends and other Support Networks

Individuals who are the subject of a SAR and/or their family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed. It is essential that the Independent Author and Review Panel have opportunities to hear these experiences and perspectives and that these contribute meaningfully to the final Overview Report. Family members can include Carers and any significant family members identified from the Genogram.

Engagement of the individual at the centre of the review and/or their family members will be discussed initially by the SAR Sub Group and facilitated by the SAB Coordinator. The individual and/or their family members will be notified of the intention to complete a SAR. Information will be provided outlining what a SAR is (See Appendix 5: Guidance Leaflet for Family Members, Friends and Care Givers), and an opportunity will be offered to give the individual and/or family members time to discuss the process in more detail with the Independent Author. The individual and/or their family members will also have the opportunity to contribute to the terms of reference should they choose to.

The Independent Author, via the SAB Business Unit, will be the main point of contact for the individual and/or their family throughout the review. The SAB Manager will arrange an independent advocate should this be required. Where such services exist, consideration should be given to signposting the individual and/or their family members to support services independent of the review. For example, [AAFDA](#), in certain circumstances would be able to offer independent guidance and support throughout the review.

As a minimum, individuals and/or their family members will:

- be notified of the review process, what that means for them and how they can access support, including impact of media coverage.
- agree the level and frequency of contact to ensure they are kept informed.
- be supported to contribute to the review process, either in writing, by meeting with the Independent Author, sharing views via a third party or by other means identified by the Review Panel.
- be informed of the publication of the report in a timely manner, including the likelihood of media interest.
- be provided with a read-only, pdf, copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version. A 'hard' copy of the report should not be provided until the report is in the public domain.

11. Agency Representatives on the Review Panel

The agencies that will be represented on the Review Panel will be agreed by the SAR Sub Group. Their agencies will have been involved in the case but the representative themselves will not be directly involved in the case. Representatives will have sufficient knowledge of the agency and practice within it.

Representatives will:

- attend and contribute to panel meetings (or learning events/audits depending on methodology used)
- be consistent, deputies will be permitted in exceptional circumstances
- contribute agency information and/or specialist knowledge to the review
- support the development of a positive learning environment across the SAB and support the Independent Author to extract learning from the review
- analyse information provided and support the Independent Author to develop review recommendations
- have an awareness of the Legislation and Statutory Guidance in relation to SARs and ensure that appropriate learning is developed whilst adhering to review timelines
- quality assure drafts of the Overview Report and Executive Summary, ensuring that the review is of a sufficiently high standard and sufficiently anonymised in preparation for publication.

12. Parallel Processes

12.1 Principles

The Independent Author and Review Panel members will consider how the SAR process is linked with other relevant investigations, such as Mental Health Homicide Reviews, Child Serious Case Reviews, Domestic Homicide Reviews or Learning Disability Mortality Reviews (LeDeR), how duplication can be avoided and how these can potentially dovetail at the beginning of the process. Consideration of other relevant investigations should inform the development of the Terms of Reference. The Independent Author will maintain contact with the lead personnel of all parallel reviews or investigation processes, and to ensure that any coordination and joint commissioning arrangements are effective.

12.2 Joint Borough Safeguarding Adult Reviews

Safeguarding Adult Reviews held jointly with other Boroughs will adopt the learning and improvement framework of the Borough hosting the review. Learning for the SAB from these reviews will be facilitated by the SAB SAR Sub Group.

12.3 Concurrent Police Investigations or Judicial Proceedings

The SAR will need to take criminal investigations and Coroners Inquiries into account to ensure that relevant information can be shared without significant delays to the review process.

Where a concurrent ongoing criminal investigation is identified, the Review Panel will make contact with the Senior Investigating Officer, early in the process and then regularly, via the police representative on the Review Panel, to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or defendants in a future criminal trial.

12.4 Her Majesty's Coroner

Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These questions will usually be related to a case:

- where there is an obvious and serious failing by one or more agency
- where there are no obvious failings, but the actions taken by agencies 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)

- where the Coroner identifies deaths that fall outside the requirement to hold an inquest but follow up enquiries or actions.

In the above situations, the SAB should consider instigating a SAR.

Her Majesty's Coroner may want to be in receipt of the final Overview Report. The SAB Business Unit will work in conjunction with the SAB Independent Chair regarding communication with the Coroner's office on behalf of the SAB.

13. Practitioner Learning Events

The Independent Author and Review Panel will determine if a Practitioner Learning Event will support the review process and provide additional multi-agency learning. If a Practitioner Learning Event is to be held this will be organised by the SAB Coordinator. It is an expectation that the Independent Author, members of the Review Panel (this must include statutory agencies), managers who collated the Agency Reports/Summaries and key practitioners identified from agencies will attend this event. The event will be quorate if the Independent Author considers there is appropriate representation to conclude adequate learning without having to duplicate a further meeting.

The Practitioner Learning Event will seek to:

- be trusted and safe experiences for practitioners and encourage honesty and transparency.
- determine what agencies and individuals involved in the case might have done differently that could have prevented harm or death.
- identify lessons learned that can be applied to practice.
- share information between agencies to obtain maximum benefit.
- identify recommendations for consideration by the Review Panel.
- provide practitioners with the perspective of the individual and/or their family members.

More than one meeting may be required to ensure the contribution of key practitioners to the learning process. It may be appropriate to host separate meetings for reflection and confirmation of the learning points.

14. Resolving Disagreements

Where disagreements occur, they are to be resolved, wherever possible, through the chosen methodology (i.e. Practitioner Learning Event and/or traditional review model with Panel meetings). However, in order for the Independent Author to maintain independence any disagreements which cannot be resolved will be noted in the Overview Report.

15. The Final Overview Report and Executive Summary

The Overview Report brings together the learning, themes identified from the review and analyses and comments on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the adult and what actions need to be taken to prevent an occurrence happening in the future. The Overview report will also contain findings and recommendations of practical value to agencies and professionals. The Overview Report will be anonymised and written concisely, in plain English.

The Executive Summary is a short opening section of the Overview Report summarising the key aspects in such a way that readers can rapidly become acquainted with the contents.

16. Presentation of Overview Report and Executive Summary to SAB

16.1 Presentation Process

The Independent Author will present the Overview Report and Executive Summary to the SAB, supported by the Chair of the SAR Sub Group. It may be necessary to arrange an Extraordinary Meeting of the SAB for this purpose. The report will be available at least five working days prior to the SAB Meeting.

16.2 SAB Responsibilities

Through the presentation of the Overview Report, the Independent Chair and Review Panel will make their recommendation to the SAB concerning the use of the real name of the individual or a pseudonym. Ultimately, the SAB will make the final decision. Similarly, the Independent Chair and Review Panel will make recommendations to the SAB in relation to information that should be anonymised or redacted within the Overview Report, such as the name of a Care Home or GP practice. Ultimately, the SAB will formally agree the format of what is to be published.

Primarily, the SAB will be concerned with what needs to be learnt, where agencies and practice require improvement and how any programme of action will lead to sustainable improvements. The SAB may identify additional learning to inform strategic direction for individual agencies.

The Overview Report and Executive Summary will be signed off by the SAB.

16.3 Publication Responsibilities

It will be the responsibility of the SAB to determine publication of the review. There is no requirement for the SAB to publish a SAR that it has commissioned. However, Statutory Guidance does identify that, *'In the interest of transparency and disseminating learning the SAB should consider publishing the reports within the legal parameters about confidentiality'*. As such, whether publication is approved, will be determined on a case by case basis and consideration will need to be given to the specific details of each SAR.

Before the Overview Report can be published the SAB will make formal decisions based on the following:

- Is the report accurate in terms of content?
- Is the report thorough in terms of analysis?
- Should this report to be published in full or as an Executive Summary? It is not acceptable to publish a 7-minute briefing only.
- Does approval for publication need to be agreed subject to further consultation with the family?

Options for publication include, but are not limited to, publishing on the OSAB website or sharing with the National SAR Library.

17. Media and Communications Strategy

17.1 Agency Involvement

Issues related to media and communication issues will usually be coordinated by the Council's Communications team. This will be done in collaboration with the PR and Communications Sub Group alongside the Communications teams of the other agencies involved. The SAB Independent Chair will release a statement alongside a published report, where appropriate, concerning how the learning will be used to inform practice.

17.2 Publication Process

In preparation for the publication of a SAR the SAB Business Unit will:

- agree a date for publication
- ensure the Review Panel have received the final version of the Overview Report
- agree publication style i.e. proactive press statements or direct publication on website
- liaise with the Council Communications team about potential for press interest
- inform individual and/or family members by letter
- inform Independent Author
- inform SAB members of the intention to publish the Overview Report on the SAB websites, including details of the information to be provided alongside with the report, such as the SAB Independent Chair's statement, a 7-minute briefing or an explanation about delays in publication
- inform lead member and Chief Executive and consider if an elected members brief is required
- liaise with Panel members so that their Communications teams can be alerted (Review Panel members to provide communication lead from their respective agency)
- circulate the final version of the Overview Report to Communication leads, as required
- ask partner agencies to have their own statements ready (liaison should take place with Council Communications team about prepared statements).

The SAR will be published on the OSAB website and sent to the Social Care Institute of Excellence (SCIE) for publication on their website.

If partners have media queries they must liaise with the Council Communications team before making a response so that the level of exposure and risk can be assessed.

17.3 Media and Communications Strategy in Preparation for an Inquest

The SAB Business Unit will liaise with the Council Communications team/PR & Comms Sub Group regarding a statement to be made by the SAB Independent Chair on behalf of the SAB. The statement will be prepared in advance of an Inquest. The statement will be made available to partner agencies through Review Panel members and can be used to assist agencies with responses to media enquiries where appropriate.

18. Action Plans

18.1 Developing Action Plans

Following Board approval of the Overview Report and Executive Summary, a clear Action Plan will be developed by the SAR Sub Group with a focus on improving outcomes for adults at risk. Actions will be Specific Measurable Achievable Realistic and Time bound (SMART) and clear action owners will be assigned. The following will be included in the Action Plan, as standard:

- A timeline for publication of the report and where possible a date identified.
- Action taken by the SAB to share the findings of the report with the individual and/or their family members and practitioners who contributed to the Practitioner Learning Event.
- Action taken by the SAB to share the lessons learned and practice impact with the wider workforce in the local area.

18.2 Monitoring Implementation of Action Plans

Single and/or multi-agency actions developed in response to Overview Report recommendations will be delegated to SAB Sub Groups for delivery where appropriate. The SAR Sub Group will retain oversight of these actions to ensure that they are achieved. The Chair of the SAR Sub Group will present updates to the SAB on a bimonthly basis.

The SAR Sub Group will hold Scrutiny Panel sessions every three months to review progress. Action owners will be asked to attend to provide evidence to demonstrate how actions have been implemented and discharged, and what difference this has made. The SAR Sub Group will determine the members of the Scrutiny Panel members and Scrutiny Panel sessions will take place during scheduled SAR Sub Group meetings to minimise the additional demand

on SAR Sub Group members. Specific times will be allocated to action owners on the day of the Scrutiny Panel sessions and evidence may be submitted in advance in writing. Attendance can be in person or virtually via Microsoft Teams.

Where actions are delegated to an OSAB Sub Group, a representative from the Sub Group will be delegated to attend the Scrutiny Panel session and deadlines will be set to allow there to be sufficient time to meet and develop responses. Where there are no plans to address outstanding actions, or agreement cannot be achieved at the Scrutiny Panel session in the first instance, the actions will be escalated to the Adult SAB for ownership and onward accountability.

If there is a request in advance of a Scrutiny Panel session to extend the deadline for the action, the SAB Manager will discuss this with the SAB Independent Chair and relevant SAB Member for agreement.

19. Complaints & Escalation Procedure

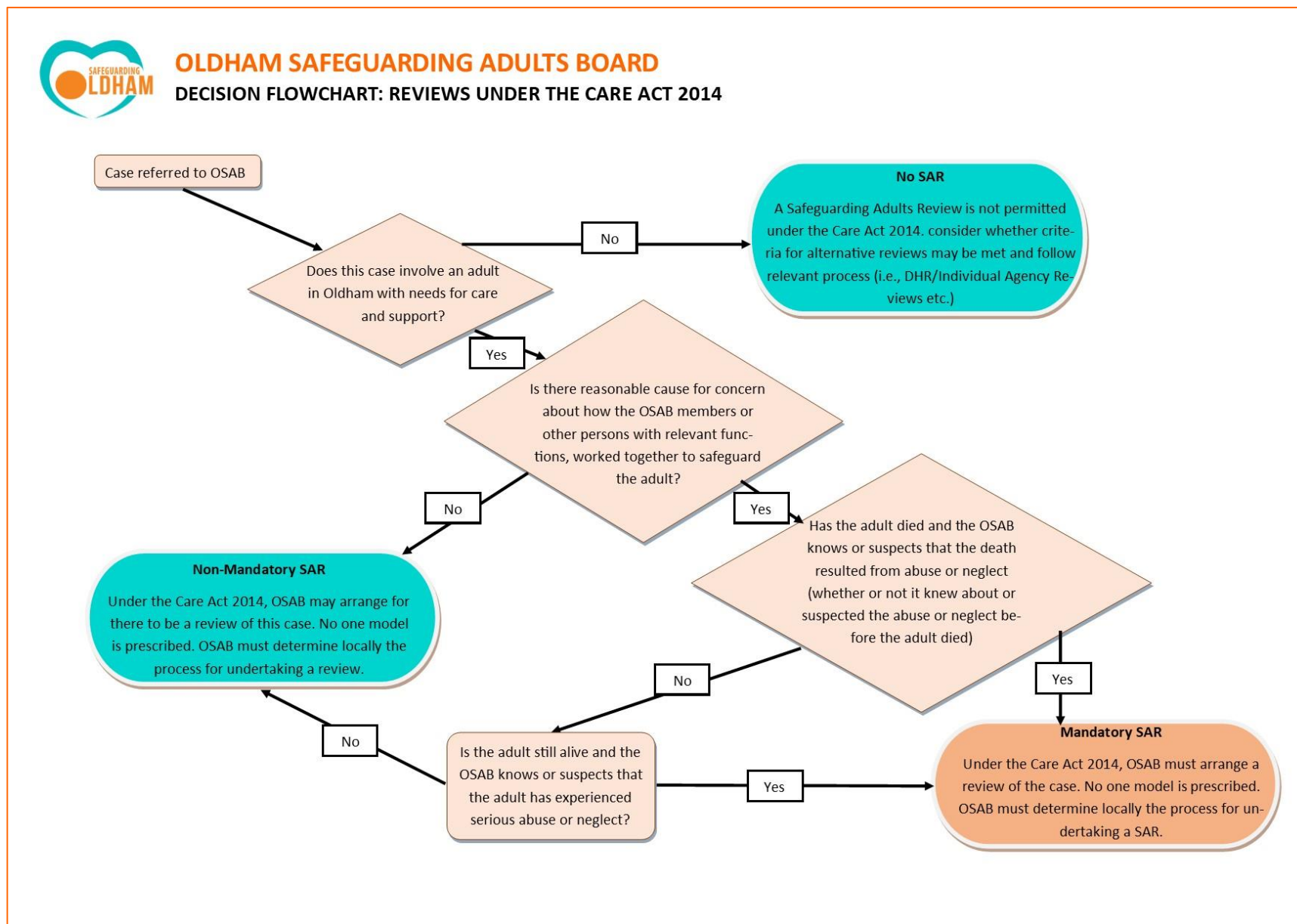
The SAB Manager, following consultation with the SAB Independent Chair, will initially respond when a complaint is received about a SAR is received, with a written response within 28 days of receipt. If the complainant is dissatisfied with the response, they should contact the SAB Manager who will arrange for their complaint to be considered by the SAB Independent Chair. The SAB Independent Chair will provide a further written response within 28 days of the complainant contacting the SAB Manager.

All written complaint responses will include details of how to contact the Local Government Ombudsman. The SAB Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation.

20. SARs and the SAB Annual Report

The Care Act 2014, Schedule 2, mandates that the findings from all completed and ongoing SARs will be reported in the SAB Annual Report alongside actions taken, or actions the SAB intends to take, in relation to those findings and where it decides during that year not to implement a finding of a SAR, the reasons for its decision.

Appendix 1: OSAB Decision Flowchart: Reviews Under the Care Act 2014





OLDHAM SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW SUB GROUP: REFERRAL FORM

To be submitted to: OldhamSafeguardingAdultsBoard@oldham.gov.uk
 You will receive e-mail confirmation of receipt of your referral within 5 working days

Section 1: Referrer Details

Date of Referral:	
Referrer's Name:	
Agency:	
Address:	
Email:	
Tel:	

Section 2: Information about the Index Adult

Forename(s):		Date of Birth:	
Surname:		Gender:	

Address

Ethnicity					
White		Black or Black British		Other Ethnic Groups	
British		Caribbean		Chinese	
Irish		African		African	
Other		Other Black Background		Any Other Ethnic Group	
Mixed		Asian/Asian British			
White & Black Caribbean		Indian		Not Stated	
White & Black African		Pakistani			
White & Asian		Bangladeshi			
Any Other Mixed		Any Other Asian			

Religion:	
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Does the individual require an advocate?	
Does the individual have Care and Support Needs/Significant Medical Information?	

Residential Status at Time of Incident					
At Home:		With Relatives:		At Home with Support:	
Residential Home:		Nursing Home:		Hospital:	
Other (Please specify):					

Please list the agencies/services known to be involved with the person:	
Please provide brief detail any other proceedings or investigations that you are aware of relating to this person:	

Section 3: Family Composition

Name	Date of Birth	Relationship To index adult	Address

Section 4: Details of the Incident/Death

Type of Incident			
Death:		Serious Injury/Abuse:	

Date of Incident:	
Date of Death:	
Incident Information:	
Information about other relevant parties i.e. carers, other individuals or family members:	
Background Information/Context to situation/Environment:	



OLDHAM SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULT REVIEW SUB GROUP: SAR DECISION DOCUMENT

To be completed by the SAB Coordinator in conjunction with the Chair of the SAR Sub Group.
 The Chair of the SAR Sub Group will lead the Screening Meeting discussions and approve the completed form
 before submission to the SAB Independent Chair.

Section 1: Details of the Screening Meeting

Date:			
Chair:			
Attendees:	Name	Agency	
Was the Meeting Quorate?	Yes	No	
Case discussion: Summary of case discussion at Screening Meeting			

Section 2: Recommendation

Does the case meet the criteria for a SAR? (Please mark all that apply)			
An adult with care and support needs (whether or not those needs are met by the Local Authority) in the Safeguarding Adults Board’s (SAB) 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			
An adult with care and support needs (whether or not those needs are met by the Local Authority) in the SAB’s area has not died, but the SAB 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. 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.			
And/Or			
The OSAB has discretion to undertake a SAR in other situations where it believes 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			
The OSAB can also consider conducting a SAR into any incident(s) or case(s) involving adult(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review.			
Was it agreed that the case meets the criteria for a SAR?	Yes	No	
Explanation (including if the recommendation was unanimous or not. If not, please record attendees who dissented from the majority opinion and their reasons)			
The SAR Sub Group reached the unanimous decision that...			

Section 3: Recommendations for the Review/Audit

Review Dates	From		To	
What events should the review concentrate on?				
What aspects of the case or key lines of enquiry should the review pursue?				
What learning do you expect to gain from the review?				
Should Family/Significant Others be involved in the review? (If Yes, please record names and relationship to the subject(s) of the review and how their participation will be facilitated)				
Which Agencies should be involved in the review? (Please record Agency Name and Name or Designation of the representative, if known)				
If the case <u>does meet</u> the criteria for a SAR, should another type of review be undertaken? (Please specify the type of review recommended)				
<ul style="list-style-type: none"> • Traditional case review • Action learning approach • Peer review approach • Thematic review • Single Agency Individual Management Review • Other (please specify) 				
Which agency should be responsible for discussing OSAB outcome letter with family/significant others? (Please record Agency Name and Name or Designation of the representative, if known)				

Section 4: Independent Chair Decision

To be completed by the SAB Independent Chair and returned to the SAB Coordinator.

Decision (Please record reasons for the decision)	
Name:	
Date:	
Signed:	

Appendix 5: Guidance Leaflet for Family Members, Friends and Care Givers

What is the Oldham Safeguarding Adults Board (OSAB)?

The Oldham Safeguarding Adults Board brings together the key organisations who work with vulnerable adults, or those at risk, across Oldham in order to make sure that they are working effectively in partnership to keep adults safe; this includes Health Trusts, Police, District Councils, Adult Social Care Services and Probation.

What Are Safeguarding Adult Reviews (SARs)?

Safeguarding Adult Reviews are one way to improve how well services respond when there have been events that resulted in a death or serious injury and with the aim of preventing what happened to your family member happening to others. The review will try to ensure that public bodies like social services, councils, police and other community based organisations understand what happened that led to the death or serious injury of your family member and identify where responses to the situation could be improved. From this, the public bodies hope to learn lessons including those which impact how they work together. The review will not seek to lay blame but to consider what happened and what could have been done differently. The review will also recommend actions to improve services in the future. Safeguarding Adult Reviews are part of the Care Act 2014 and became law from 1st April 2015.

Who Will Undertake the Review?

These reviews are commissioned by the Safeguarding Adults Board. An independent person, who has not been involved in the case or in Oldham services, will lead the review and write the final report. A review team will be formed of members of local statutory and voluntary bodies. The review team will not include any professionals who have been directly involved in the case. The review team will look at how the entire community's response could be improved to help better support victims.

Your Involvement in the Review

We think friends, family members and other people who knew the victim and perpetrator are the best people to help officials understand what happened. Victims often tell their family about the abuse they suffered and, sometimes, about their experiences in asking for help. It follows that family members can help public bodies to identify what lessons should be drawn from this tragedy. You will be given the opportunity to share your views and comment on the services you, or the adult at risk, received. You will be contacted and offered the chance to attend a meeting with the Independent Author conducting the review to share your views at the start of the process.

You will also be informed when the review is completed, and a further meeting will be offered to discuss the findings of the review before publication. The report will be published on the OSAB website. Conducting a review is a statutory obligation, therefore families are not asked to consent.

If you want to know more about Safeguarding Adult Reviews and the Oldham Safeguarding Adults Board contact ***** or visit our website *****

Taking Part in the Review

If you do decide to take part in the review, you will be asked by the review team to share your understanding of what happened and why. This might include your thoughts, memories and point of view on any aspect of the review. The review team are trying to ensure that the circumstances around the death or serious injury of your family member are understood as far as possible and that learning is used to prevent further deaths or serious injuries in the future. As part of this, you might know about attempts your family member made to seek help from public bodies, community organisations and others because sometimes not all of these contacts are known to the review team. You might also want to recommend other persons you think should be invited to submit a view.

You can give your thoughts and views in writing or via a recording, via a telephone conversation or at a face to face meeting with the Independent Author. The Independent Author would ask questions to assist the discussion and the whole process would last no longer than a few hours or as long as you feel able to participate.

What Happens to the Information You Share?

The information you share will help the review team to build a comprehensive picture of what happened before the death or serious injury and in turn will help the team formulate their recommendations for change. These recommendations will then be put into an action plan. Your input will be confidential and you will not be named in the review report. Your contribution will be valuable and may help change the way the community, including public bodies, respond to serious situations in the future.

How Long Will the Review Process Take?

The review should be completed within six months however the review period could be longer, for example because of potential prejudice to related court proceedings. Every effort should be made while the review is in progress to capture points from the case about improvements needed and to take corrective action.

What Does the Review Produce?

- A detailed report and summary of that report which will be available on a public website.
- An action plan to ensure any recommendations made in the report are taken forward appropriately.

Next Steps

The decision to take part in this review is entirely yours and if you do not wish to take part your decision will be respected. If you are happy for us to do so, we will contact you again to let you know when the review has been completed. If you would like to take part or have any further questions about the review process, please contact the person who has signed the letter attached to this leaflet. They will either answer your questions or direct you to someone who can.