Swindon Safeguarding Partnership

Safeguarding Adults Review (SAR) Policy

Conducting safeguarding adults reviews in Swindon under Section 44 of the Care Act 2014

Based on Leicester SAB Policy, Authors: Jo Reed, LSAB Board Officer & Lindsey Bampton, LSAB Manager
Date: June 2022

FOREWORD

One of the core duties of a Safeguarding Adults Boards (SAB) which in Swindon is the Swindon Safeguarding Partnership (SSP) is to review cases in its area 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 adults 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.

IN ORDER TO ACHIEVE THE AIMS OF SAFEGUARDING, IT IS IMPORTANT TO 'SUPPORT THE DEVELOPMENT OF A POSITIVE LEARNING ENVIRONMENT ACROSS THESE PARTNERSHIPS AND AT ALL LEVELS WITHIN THEM TO HELP BREAK DOWN CULTURES THAT ARE RISK-AVERSE AND SEEK TO SCAPEGOAT OR BLAME PRACTITIONERS'

(DEPARTMENT OF HEALTH AND SOCIAL CARE STATUTORY GUIDANCE)

CONTENTS

1. Introduction

1.1 Purpose of Policy

The purpose of this policy is to outline the process for the management of notifications of Safeguarding Adults Reviews (SARs) in Swindon under Section 44 of the Care Act 2014. This protocol has been developed to simplify and clarify our local process by:

- Providing an overview of how to notify serious incidents which may be suitable for review
- Enabling a consistent approach to SAR decision making and practice
- Demonstrating how local processes comply with legal requirements and best practice
- Clarifying review timeliness in line with legislation and statutory guidance
- Providing a resource to enable those involved in reviews to answer common questions
- Clarify local roles and responsibilities
- Provide transparency about the review process
- Support practical planning and preparation of reviews

1.2 Legislation and Statutory Guidance

The Care Act 2014 outlines a Safeguarding Adults Board's core duty to conduct safeguarding adults reviews in accordance with Section 44 of the Act, which can be found here: http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

Statutory Guidance published by the Department of Health and Social Care in relation to safeguarding adults reviews can be found here: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2. Purpose of a SAR, Local Process, & Timelines

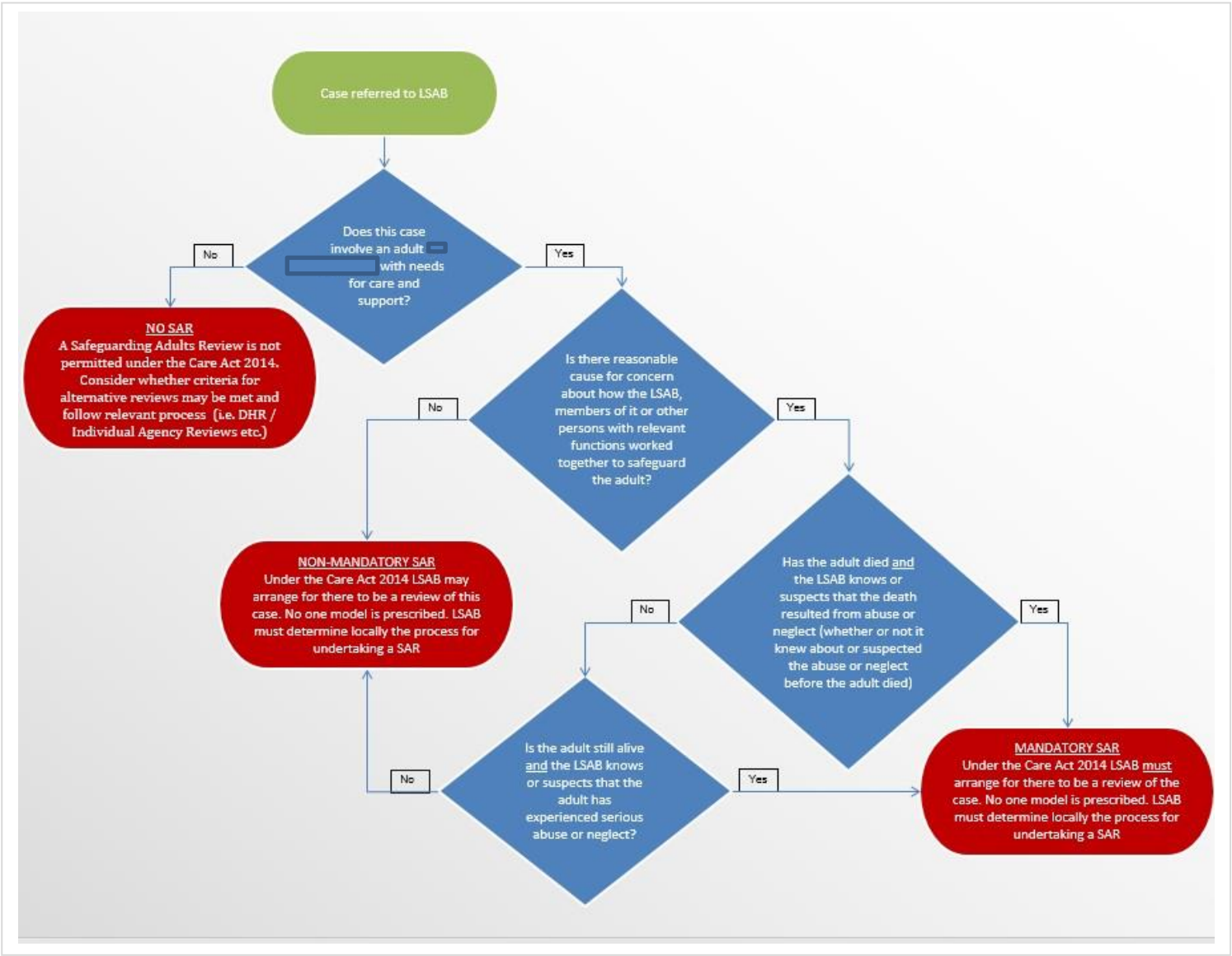
2.1 Purpose of a SAR

The purpose of a SAR is noted in the Statutory Guidance as being 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.*'

2.2 SAR Criteria

The criteria for conducting a safeguarding adults review can be found under Section 44 of the Care Act 2014 (see above link). Locally, a flowchart has been developed to support the Safeguarding Adults Board (SSP in this locality) with making decisions about whether or not these criteria havebeen met:



2.3 Referral & Decision

SAR referrals should be made via an organisation's safeguarding lead, using the SSP SAR referral form (Appendix 1) and e-mailed to safeguardingpartnership@swindon.gov.uk

Upon receipt of the referral, the SSP BSU will, within 5 working days, send an email to the referrer confirming receipt. The SSP BSU will also notify the followingindividuals that the referral has been made:

- Strategic partnerships manager SSP/CSP
- Partnership Development Managers Safeguarding

- SSP Practice Review Group Subgroup Chair
- Statutory partners representatives

A statutory partners representative meeting will be organised to discuss the referral **within 2 weeks** from the date that it is received.

After the SAR referral has been heard, the statutory partners representatives may decide to request further information to support the decision-making process. Where this is required, the Part 2 requests should be completed, and relevant information provided by organisations, **within 10 working days** of receiving the initial request and in time for the information to be considered at an additional Practice Review Group (PRG) meeting.

Having considered the SAR referral (and where relevant, the subsequent Part 2 information) it will be the responsibility of the PRG to make a recommendation to the SSP Executive Committee whether or not to commission a safeguarding adults review (see Appendix 2 for relevant form).

The delegated authority for the decision making under the Care Act sits with the three responsible authorities for the SAB in Swindon - LA, ICB & Police and this is held by the SSP Executive Representatives who will make the decision as to whether or not the SAR should be commissioned.

The SSP Executive Committee will notify the PRG of their decision.

2.4 Review Timeline

Section 14.173 of the Statutory Guidance states, '*The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 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*'.

To ensure that reviews are completed in line with statutory guidance, the following timeframes for safeguarding adults reviews are set out below:

SWINDON SAFEGUARDING PARTNERSHIP
SAR PROCESS CHART FROM DATE OF REFERRAL RECEIPT

<table>
<tr><td>5 days</td><td colspan="2">Referral to be submitted on Referral Form to Business Unit from Agency Safeguarding Leads.
safeguardingpartnership@swindon.gov.uk</td><td></td></tr>
<tr><td>10 days</td><td colspan="2">Arrange and hold meeting with three Statutory Partners to discuss referral</td><td></td></tr>
<tr><td>WITHIN 4 WEEKS</td><td colspan="2">Agency Case Information Pro-Forma completed by each PRG member.</td><td rowspan="3">WITHIN 6 MONTHS
Timescales may differ if there are ongoing criminal or civil proceedings or an Inquest</td></tr>
<tr><td colspan="3">Recommendations made at next PRG Subgroup meeting to Chair.</td></tr>
<tr><td rowspan="3">WITHIN 8 WEEKS</td><td>Refuses request
Refer to SSP Exec Committee for final decision
Notify referring agency of decision and reason
Consider/recommend another process</td><td>Agrees request
Complete Part 3 overview and send SSP Exec Committee for scrutiny and of decision.
Notify referring agency & all constituent agencies
Notify all Partnership Members
Request records are secured
PRG to set up Panel, Chair and Scoping Meeting.</td></tr>
<tr><td colspan="2">Scoping meeting to set the terms of reference, timescales, engagement/involvement of family, nominate Lead Agency Report Authors. Letters to all agencies requesting attendance of Authors at Authors' Briefing session.</td></tr>
<tr><td colspan="2">Authors Briefing, chaired by Independent Report Author. Letters to all agencies setting out requirements of reports, anonymisation/security standards, templates and set timescales. Set future meeting dates.</td></tr>
<tr><td>WITHIN 6 WEEKS</td><td colspan="2">Agency Report Authors commence reviews and submit reports securely to Business Unit in line with timescales. Also required to submit Reflective Review Day attendee details. Business Unit distribute reports to Panel for quality assurance purposes. Business Unit securely disseminates agency reports to all Review Day Attendees after sign off.</td></tr>
<tr><td rowspan="3">WITHIN 8 WEEKS</td><td colspan="2">Reflective Practitioner Session held to debate findings and agree issues and learning points</td></tr>
<tr><td colspan="2">First Draft Overview Report distributed securely to Panel to agree. Overview Panel meets with Independent Author to draft main learning points and recommendations. Report distributed to Review Day attendees in readiness of Recall Day.</td></tr>
<tr><td colspan="2">Overview Panel considers final draft recommendations and process for monitoring any single agency recommendations. Communication planning to include debriefing of family and staff to be arranged. Report submitted to PRG for sign off.</td></tr>
<tr><td rowspan="2">WITHIN 4 MONTHS</td><td colspan="2">Draft Overview Report and Action Plan to SSP Chair and Partners for final ratification.</td><td rowspan="2">Action Plan Timescale
Implementation on case by case basis</td></tr>
<tr><td colspan="2">Action Plan implemented and overseen by PRG who will assure SSP Executive Group when recommendations/actions are signed off.</td></tr>
</table>

3 Contact with the Individual at the Centre of the Review and/or Their Family

3.1 Statutory Guidance & Best Practice

The ADASS and LGA publication 'Making Safeguarding Personal for safeguarding adults boards' (Lawson, 2017) recommends that '*Safeguarding adult reviews (SARs) and other review processes engage with people in receipt of support and services and/or their families'*[1]
Department of Health and Social Care statutory guidance outlines the following in relation to the adult, their family, and friends when it comes to SARs: *'7.3 There is also a separate duty to arrange an independent advocate for adults who are subject to a safeguarding enquiry or Safeguarding Adults Review (SAR)…*

14.54 The Care Act requires that each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them…
14.165 Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.'

3.2 Local Approach

Engagement of the individual at the centre of the review and/or their family will be authorised by SSP PRG and facilitated by the SSP BSU. To enable the individual and/or their family to be fully briefed on what to expect from the review, contact will be made after the review methodology has been agreed. However, wherever possible contact must be made early enough to enable the individual and/or their family to contribute to the terms of reference of the review should they choose to.

The Development Manger will be the main point of contact for the individual and/or their family throughout the review. Early discussions will take place to agree how they wish to be involved. Should an independent advocate be required, SSP BSU will liaise with Swindon Borough Council Adult Social Care in order to arrange this.

Where such services exist, consideration should be given to signposting the individual and/or theirfamily to support services independent of the review. One such example is AAFDA who in certain circumstances would be able to offer independent guidance and support throughout the review https://aafda.org.uk/

4 Roles and Responsibilities:

4.1 SSP Executive Committee:

- Decide whether or not a SAR should be undertaken
- In conjunction with SSP Board Members, sign off final Overview Report, Executive Summary and Action Plan ensuring that multi-agency recommendations have Specific Measurable Achievable Realistic and Time bound (SMART) actions and clear action owners
- In conjunction with SSP Board Members make a decision about publication

4.2 SSP Practice Review Group Members:

- Scrutinise and analyse information provided to support the group in making

recommendations to the SSP Executive Committee
- Coordinate additional information from own agencies as required to make a recommendation about whether or not to commission a SAR
- Coordinate chronology from own agency
- Determine SAR methodology
- Agree draft Terms of Reference
- Agree draft scoping period
- Confirm organisations to be involved in the review. Confirm initial membership of panel (or attendance at learning event etc. dependant on the review methodology)
- Approve any changes to Terms of Reference and scoping period
- Approve any changes to panel membership
- Ensure that relevant members of own organisation (including Board Member, IMR author, SAR Panel Member) are updated about commissioned SARs (including sharing review timeline, terms of reference, emerging learning as appropriate)
- Quality assure final draft of Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners
- Ensure own organisation is adequately represented at relevant meetings (i.e. PRG meetings, SAR panel meetings, SAR publication meetings) and in key discussions
- Practice Review Group chair to chair SAR publication meetings
- Ensure that individual agency learning from SARs is shared within own organisation and that assurance is provided to the SSP Practice Development Group that this has been done
- Be the main point of contact within own organisation for single agency SAR actions updates

4.3 Panel Members / Review Participants:
- Attend and contribute to panel meetings (or learning events / audits etc. depending onmethodology used)
- Contribute agency information and/or specialist knowledge to the review
- Support the development of a positive learning environment across the partnership and support the SAR author to extract learning from the review
- Analyse information provided and support the SAR 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 Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners

4.4 SSP Business Support Unit:
- Project manage SARs to ensure that they are completed to a sufficient standard within an appropriate timeframe
- Prepare scoping report including draft terms of reference, draft scoping period, proposed methodology, initial panel membership and proposed timeline for the PRG's consideration
- In conjunction with PRG Chair, commission independent SAR chair/author
- Inform individual central to the review and/or their family about the SAR and remain point of contact throughout
- Provide regular updates on SAR progress both verbally and in writing at PRG
- Request and collate single and multi-agency SAR actions updates

4.5 SAR Independent Chair/Author/Facilitator:

- Review the initial panel membership

- Review and confirm Terms of Reference
- Review and confirm scoping period
- Notify LSAB Review Subgroup (who will maintain oversight) of any changes to scoping period, panel membership, terms of reference throughout the review
- Facilitate review in line with the chosen methodology
- Produce Overview Report, Executive Summary and Action Plan, ensuring that the review isof a sufficiently high standard and that wherever possible, multi-agency actions are SMARTand have allocated action owners

5. Resolving Disagreements:

Where disagreements occur, they are to be resolved wherever possible through the SAR methodology chosen (i.e. one-day learning event / traditional serious case review model with panel meetings). However, to maintain the independence of the SAR author, ultimately any disagreements which cannot be resolved will be noted in the Overview Report.

6. Information sharing and retention:

Section 44 of the Care Act 2014 states 'Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— (a) identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases'. Section 45 of the Care Act 2014 outlines compliance in relation to supply of information and can be read here: http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

The Swindon Safeguarding Partnership Information Sharing Agreement can be found on the SSP website which can be found here

Information received for the purpose of safeguarding adults reviews must not be stored for longer than necessary and must not be used or shared in any way without the prior consent of the SSP or one of its Sub-Groups.

7. Publication:

Following sign off of the safeguarding adults review Executive Summary, Overview Report and Action Plan, it will be the responsibility of the SSP Executive Committee to determine publication of the review. There is no requirement for a SAB to publish a safeguarding adults review that it has commissioned. However, statutory guidance does identify that, '*In the interest of transparencyand disseminating learning the SAB should consider publishing the reports within the legal parameters about confidentiality*[2]'. As such, consideration will need to be given to the specific details of each review and whether publication is approved, on a case by case basis.

Options for publication include but are not limited to, publishing on the SSP website or sharing with the National SAR Library. Where publication is agreed, the PRG Chair will chair SAR publication meetings as required, with meetings being supported by the SSP BSU.

[2] Department of Health (2017). Care and support statutory guidance [online] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 31 August 2018].

It will be important to note that the Care Act 2014 Schedule 2 mandates that as soon as is feasible after the end of each financial year, an SAB mush publish a report on what it has done during that year, including:

(d) the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),

(e) the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),

(f) what it has done during that year to implement the findings of reviews arranged by it under that section, and

(g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

8. Parallel Processes:

Where there are parallel processes or reviews, Statutory Guidance should be taken into consideration as follows:
'Links with other reviews

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

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

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

Locally, as soon as it is recognised that a SAR may be run in parallel with another review (for example an SCR, a Learning Disability Mortality Review (LeDeR) or a DHR), the Strategic Partnerships Manager will make contact with the relevant bodies running the other review/s in order to minimise avoidable duplication. This is likely to involve arranging a joint meeting to establish at the outset how the SAR process will dovetail into any other review running parallel.

9. Lessons Identified & Lessons Learnt

Single agency actions developed in response to single agency IMR recommendations, will be monitored by the Practice Review Subgroup to ensure that they are achieved. Single and/or multi-agency actions developed in response to Overview Report recommendations will also be monitored by the PRG to ensure that they are achieved.

Upon all the actions from a review being complete, the PRG will refer the review to the PQA group with a request that assurance is sought that the completed actions have made a difference in practice and that learning has been embedded i.e. assurance that lessons identified have indeed been learnt. Where it is found not to be the case, remedial action will be taken.

10. Sharing learning

Once a SAR has been completed and signed off at Board, the PRG will refer the review to the Practice Development Group (PDG):

- *The PRG will refer in any **multi-agency** training related recommendations from Safeguarding Adults Reviews (SARs) to the PDG for action. It will be the responsibility of the PDG to action these recommendations by commissioning multi-agency training. The PDG will provide feedback of outcomes to the PRG who will then sign them off as complete.*

- *Each partner will be responsible for sharing the learning from SARs within their own agency. The PDG will be responsible for collating assurance that this has been completed.*

- *In addition, awareness-raising from SARs will be facilitated to staff by the PDG through a variety of methods i.e. conferences, multi-agency workshops, briefing papers, presentations at relevant meetings.*

Appendix 1 – SAR Referral Form

SAR - Consideration of case for Review by Swindon Safeguarding Partnership – Part 1

Use this form to request a Safeguarding Adults Review or a case discussion by the Practice Review Group.

In April 2015 the requirement to undertake SARs became statutory through the Care Act 2014, Section 44 of which states:

(1) A Safeguarding Adult Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult **and**

b) either of the following conditions are met—

(2) Condition 1 is met if—

a) The adult has died, **and**

b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if—

a) The adult is still alive, **and**

b) The SAB knows or suspects that the adult has experienced serious abuse or neglect

A case discussion can be requested by any agency where it is believed that there is learning from a case that was or should have been managed as a safeguarding adults concern and may not meet the criteria for a SAR (e.g. the issue is a single agency concern, unclear of meeting the SAR criteria).

Section 1:

1.1 Referral Details

Date of notification:	
Name of referrer:	
Agency:	
Address:	
Tel No:	
E-mail:	

1.2 Adults Details

Adults First Name:	
Adults Surname:	
Any Known Aliases:	
Date of birth: *(DD/MM/YYYY)*	
Date of death: *(DD/MM/YYYY) (if applicable)*	
Address:	

Gender:		Male		Female		

Service User Group – please tick the relevant box

Primary Support Reason		**Secondary Support Reason**					
	Physical Support		Personal Care Support		Access & Mobility Only		
	Sensory Support		Visual Impairment		Hearing Impairment		Dual Support
	Support with Memory & Cognition						
	Learning Disability Support						
	Mental Health Support						
	Social Support		Support to Carer		Substance Misuse Support		
			Asylum Seeker Support		Support for Social Isolation/other		

Ethnic origin – please tick the relevant box

(A) White		(B) Mixed		(C) Asian or Asian Britain	
	British		Asian and White		Indian
	Irish		Black African and White		Pakistani
	Any other White background		Black Caribbean and White		Bangladeshi
			Any other mixed background		Chinese
					Any other Asian background
(D) Black or Black British		(E) Other Ethnic Group		(F) Not declared	
	Caribbean		Please specify		
	African				
	Any other Black background				

Faith:	
Location of incident:	
Carer at time of incident:	

1.3 Family composition/significant others

Name	Relationship to Adult	DOB	Address	Legal status and/or current criminal proceedings	Ethnic origin	Are there concerns about this person e.g. potential abuser

Details of the representative/family of the adult with care and support needs

Does the adult have any family or representative as far as you are aware?

Yes ☐ No ☐ (if no move to question 1.4)

Are they aware of the SAR referral? Yes ☐ No ☐

Family member/representative contact name

Relationship to the adult

Phone number

Address

Is there any reason the family should not be contacted if a decision is made that the case meets the criteria for a SAR?

Yes ☐ No ☐ (if Yes please give details)

1.4. Agencies known to be involved with the case (please add their name and contact details and include GP)

Name	Agency	Contact details	Are they still involved?

1.5. Reason for notification (more than one box may be ticked)

• An adult died (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death.	
• An adult died in custody, either in police custody, on remand or following sentence, or an adult dies who was detained under the Mental Health Act 2005.	
• An adult is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard.	
• There was clear evidence of a risk of significant harm to an adult that was: o not recognised by organisations or individuals in contact with the adult or perpetrator or	

○ not shared with others or ○ not acted on appropriately	
• An adult has been abused or neglected in an institutional setting (e.g. Care Home, nursing home, respite provision, college or higher education).	
• An adult died while absent from or having left their home or other care setting or whilst being homeless.	
• One or more agency or professional considers that its concerns were not taken sufficiently seriously, or acted on appropriately, by another despite using the LSAB escalation.	
• One or more agency or professional considers that its concerns were not taken sufficiently seriously, or acted on appropriately, by another despite using the LSAB escalation.	
• The case indicates that there may be failings in one or more aspects of the local operation of formal safeguarding adult procedures, which go beyond the handling of the specific case.	
• The adult concerned was the subject of adult safeguarding procedures, or had previously been the subject of such procedures.	
• The case suggests that the Swindon LSAB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on.	
• There are indications that the circumstances of the case may have national implications for systems or processes or there are significant public interest or community issues.	
• Other reason *(please specify)*:	

1.6 Characteristics of Case

	Domestic abuse		Alcohol abuse		Drug abuse
	Mental Health		Fabricated illness		Neglect or acts of omission
	Sexual abuse		Parent in care		More than one adult abused
	Financial abuse		Parent is care leaver		Serious illness
	Psychological & Emotional abuse		Recent neglect		Self-Neglect
	Physical abuse		Discriminatory abuse		
	Institutional/Organisational abuse		Modern Slavery *(incl. human Trafficking or Criminal exploitation)*		
	Other features *(please specify)*:				

Is the Adult subject to: (*please tick the relevant box)*	Yes	No	Has been	Don't know
• Adult Protection Plan?				
• Care and Support Services?				
• Have criminal proceedings been instigated?				
• Has there been a conviction?				
• Is the case awaiting coroner inquest?				

1.7 Please provide a brief summary of the case and the circumstances that led to the referral including any practice issues identified.

1.8 Why do you think this meets the criteria for a SAR?

Please outline the factors that suggest the SAR criteria are met:
Please refer to the front page of this referral form and include in detail how you feel the circumstances meet the criteria for a Safeguarding Adults Review **responding fully to each separate criteria.**
For the circumstances to meet the criteria there must be concerns about how separate agencies **worked together.**

a) The adult has care and support needs / significant medial information – specify below:

b) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult. Specify below:
Supporting information to include what the abuse and neglect consisted of:
c) The adult has died (suspected to be resulting from abuse or neglect). Specify below:
Supporting information to include what the abuse and neglect consisted of:
d) The adult is still alive and suspected to have experienced abuse or neglect:
Supporting information to include what the abuse and neglect consisted of:

1.9. Please provide any additional information you think may be relevant and assist decision making

Signature:	
Date:	

Please return completed forms: safeguardingpartnership@swindon.gov.uk

Appendix 2 – Review Sub Group SAR Recommendation to LSAB Independent Chair Form

Swindon Safeguarding Partnership

Consideration of case for Review by Swindon Safeguarding – Part 2

In April 2015 the requirement to undertake SARs became statutory through the Care Act 2014, Section 44 of which states:

(1) A Safeguarding Adult Board (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:

c) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult **and**

d) either of the following conditions are met—

(4) Condition 1 is met if—

c) The adult has died, **and**

d) 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)

(5) Condition 2 is met if—

c) The adult is still alive, **and**

d) The SAB knows or suspects that the adult has experienced serious abuse or neglect

A case discussion can be requested by any agency where it is believed that there is learning from a case that was or should have been managed as a safeguarding adults concern and may not meet the criteria for a SAR (e.g. the issue is a single agency concern, unclear of meeting the SAR criteria).

Section 2 – Case Synopsis	
Summary	
Key issues/Learning (Background)	

The objective of this section of the form is to determine whether Swindon Safeguarding Partnership should consider undertaking a serious case review.

Section 3 (to be completed by the Practice Review Group)

3.1 Details of the Panel

Date of PRG:		**Chair of PRG:**	

Members of PRG present *(please list)*:

Name	**Agency**

Case discussion details:

Decision/recommendation: To undertake mandatory SAR	
Was the PRG meeting quorate?	
Comments:	
Was the recommendation unanimous?	

Comments/reasons for dissent/who?	
Was the criteria met? *(Please tick all that apply)* Abuse or neglect of an adult is known or suspected, and either:	
• The adult has died, there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the adult	
• The adult has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the adult	
Outcome:	
1) It was agreed that this case: (Please tick the relevant box)	
• Meets the threshold (Criteria) for a Safeguarding Adult Review	
• Does not meet the threshold (Criteria) for a Safeguarding Adult Review	
2) It was agreed that an alternative form of review should be recommended: (Please tick the relevant box) **Definition of terms:** *Review*: Is an evaluation designed to identify potential service delivery and procedural improvements. *Audit*: The process of systematic examination carried out to assess how successfully processes have been implemented.	
• Local Case Review	
• Management Review	
• Single Agency Individual Management Review	
• Warrants a Multi-Agency Audit	
Reasons:	
3) It was agreed that there are no multi-agency issues.	
Reasons:	
4) Any further action required?	
Please list: •	
5) Decision fed back to the referring agency?	

Yes		No		By Whom:	Date:		

SECTION 4 (to be completed by the Executive Committee of Swindon Safeguarding Partnership)

4.1 Decision

Our decision is that a Safeguarding Adult Review:
1) should take place for the following reasons:
2) should not take place for the following reasons:

Name:	
Date:	
Signed:	