BOLTON SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW PROTOCOL

Last updated – May 2025

1. INTRODUCTION

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

1.2 This protocol has been developed by the Bolton SAB and aims to ensure that there is a consistent approach to the process and practice in undertaking SARs that follows both statutory guidance and local policies. It sets out the arrangements by which the SAB will conduct SARs. It highlights the statutory duties, overall process for running and managing a SAR and how the SAB will commission such work. The protocol is part of the Bolton Safeguarding Adults Policy and Procedures. Bolton Safeguarding Adults Policies and Procedures

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2. LEGAL FRAMEWORK

Mandatory Duty to complete a SAR:

2.1 SABs must arrange a SAR, when 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:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. *(Care Act 2014 S44 (2) Condition 1)*

- An adult in its area is still alive, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. *(Care Act 2014 S44 (3) Condition 2)*

  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 (whether because of physical or psychological effects) as a result of the abuse or neglect.

Discretionary Duty to complete a SAR:

2.2 Section 44(4) permits SABs discretion to arrange for a SAR in any other situations involving an adult in its area with needs for care and support where there are valuable lessons to be learnt with the aim of improving how agencies work together, to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future.

Duty to Cooperate

2.3 Section s44(5) requires each member of the SAB to co-operate with the review to assist with identifying the lessons learnt from the case and apply those lessons to future cases. As such, this protocol applies to all SAB partners who have collective responsibility to support Bolton SAB to meet its statutory duties.

2.4 In recognition that partner agencies and organisations have their own internal governance and learning structures, these guidelines seek to complement and build on single agency arrangements by adding a multi-agency approach. Working collaboratively, partner agencies can learn lessons from cases where there may have been multi-agency failings and use this learning to improve future joint working.

2.5 These guidelines can support professionals to decide when to refer a case for consideration of a SAR as well as providing guidance on the SAR process, action planning for implementation of recommendations arising from SARs and in providing assurance that partner organisations have implemented learning in line with duties under s44(5) Care Act.

Duty to Share Information

2.6 Section 45 Care Act sets out a requirement for any person likely to have information relevant to the exercise of SABs functions (including the completion of a SAR) to supply that information. To aid consistency this will usually be done using agreed formats, examples are given within the appendices. Information collated during the SAR process may be disclosed, if requested, as part of civil or criminal proceedings or to a Coroner. Normally, requests for disclosure of preliminary reports (such as individual partner agencies' internal management overview reports) will be directed to the relevant agency to respond to as this information is not 'owned' by the SAB.

3. PURPOSE OF A SAFEGUARDING ADULTS REVIEW

3.1 SARs should seek to determine what the relevant agencies and individuals involved with the adult might have done differently that could have prevented harm or death. This is so that lessons can be learnt from the circumstances of the adult and those lessons applied to future practice to prevent similar harm occurring again. The purpose of a Safeguarding Adults Review is to:

- Establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.
- Identify how lessons learned will be acted upon and what is expected to change as a result.
- Disseminate lessons learned, promoting effective practice and improvement action to minimise the risk of future deaths or serious harm occurring.

3.2 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences, that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive, and their participation guarded and partial. Its purpose is not to attribute blame.

3.3 The following principles apply to all reviews:

- There should be a culture of continuous learning across all organisations that work together to safeguard and promote the wellbeing and empowerment of adults.
- The approach taken to reviews should be proportionate, according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be held by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. The reviews should encourage honesty, transparency and sharing information to obtain maximum benefit for them.
- Families should be invited to contribute to reviews. Early discussions need to take place with the adult, family and friends to agree how they wish to be involved ensuring openness and engagement in the process from an early stage. Consideration should be given to offering the adult or the families an advocate to support them/ advocate of their behalf during this process.

4. SAFEGUARDING ADULT REVIEW GOVERNANCE

4.1 The BSAB Constitution and Governance sets out the duties for the SAB which includes the requirement to conduct a SAR in accordance with Section 44 of the Care Act 2014.

4.2 To support this function, the BSAB has set-up a SAR Sub-group tasked with ensuring compliance with the legal duty and supporting decision making on SAR commissioning. The membership of the SAR Subgroup includes but is not limited to the Legal Adviser to the BSAB and senior representatives from its statutory partners (the local authority, Greater Manchester Police and Bolton NHS Foundation Trust). The SAR Sub-Group will review the circumstances of each referral, to determine whether the criteria have been met to conduct a SAR.

4.3 The SAR Sub-group will review and make recommendations to the Independent Chair on behalf of the SAB to commence a SAR or not with supporting evidence and information. If the Independent Chair does not agree with the recommendation of the Sub-Group, the matter shall be listed for discussion at full board in an extraordinary meeting of the Board. A final decision shall be reached by full Board with the rationale for the decision recorded for legal challenge and scrutiny.

5. MODEL PROCEDURE

Identification and Referral

5.1 Any agency or professional may make a SAR referral to the SAB. Referrals are to be made using the Northwest SAR Referral Form, which BSAB will adopt. This referral form collects all the relevant information to support screening, it incorporates all recommendations from the SCIE Quality Markers and National Analysis of SARs and will ensure all SABs collect the same quantitative data to inform the development of a GM data set. Completed forms should be sent to

boltonsafeguardingadultsboard@bolton.gov.uk. Referrers will receive an email from the SAB Business Support Team to confirm receipt of the SAR referral.

5.2 Where SAR referrals are submitted inappropriately in place of a safeguarding concern, the referrer will be signposted to the safeguarding referral pathway and informed that the SAR referral will be considered for closure or non-progression at the next SAR subgroup meeting.

Screening / Triage

5.3 The Chair of the SAB SAR subgroup will be notified in the first instance and, if they are satisfied it is reasonable to give full consideration of the request, the SAB Board Manager will write to relevant agencies to require they complete an initial summary of their involvement. These should be completed within 10 working days.

5.4 The SAB Board Manager will ensure all relevant/appropriate information has been provided on the referral form, if the referral is not fully completed the Board Manager will contact the referrer within 3 working days to discuss the referral and ensure the referral form is completed fully prior to admission at the SAR Subgroup meeting.

5.5 The SAB Board Manager will liaise with the Chair of the SAR subgroup and where possible identify and invite the most appropriate professional to attend the SAR subgroup and present the case at the SAR subgroup meeting.

5.6 If an organisation has had contact with the adult subject to a SAR, they must ensure that they secure records at the earliest opportunity, to ensure the integrity of any documentation pertaining to the review.

Initiating a Safeguarding Adults Review:

5.7 The SAR subgroup should be notified of the referral as soon as is practicably possible and arrangements made for the referral to be considered (an extraordinary meeting may need to be convened). The decision about whether to undertake a SAR, and the nature of the SAR that is required, will need to take into account factors related to the case and the local context. The primary consideration is whether there is a mandatory/discretionary obligation to undertake a SAR, using the criteria in s44 Care Act. The rationale for any recommendations should be transparent and reached in a timely fashion. Any delays in decision-making should be referenced and explained. There should be opportunities for the adult or their representative, family and relevant partners to contribute their views and relevant information.

SAR Decision Making Flowchart:

5.8 The SAR Decision Making Flowchart provides a clear rationale as to whether the criteria have been met. The flowchart is underpinned with the criteria defined in the legal framework of the Care Act 2014 (s44) and will provide a clear rationale to why the criteria has been met or not. This approach again will support transparency and

consistency in decision making. Decision making should be timely to ensure learning has been identified and taken forward at the earliest opportunity. The use of the terminology for Safeguarding Adult Reviews as reference in the National SAR Research will be adopted:

- Mandatory SAR - Care Act 2014 S44 (s1 to 3), if conditions 1 or 2 are met.
- Discretionary SAR - Care Act 2014 S44 (4) - A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

5.9 When SAR referrals are discussed at the SAR subgroup, there is the opportunity for referring agencies to attend the meeting to present their referral.

5.10 In order for decision making to take place, there must be representation at the SAR Subgroup from the core statutory partners, Local Authority, Greater Manchester Police, and NHS Greater Manchester Integrated Care. The SAR Subgroup will be asked to identify if there is any conflict of interest. If there is then any individual with the conflict will be replaced by another agency representative.

5.11 The SAR Sub-Group meeting will be minuted to ensure that there is an accurate record of the decision-making process, detailing clearly the rationale to determine a recommendation to commence a SAR.

5.12 Wherever possible the SAR sub-group will make decisions and recommendations based on consensus within 2 months of the referral. Decisions will be made based on a simple majority. The Chair of the SAR subgroup will hold a casting vote and has ultimate responsibility for deciding on the recommended outcome of the referral, based on the proposals made by the SAR subgroup. If necessary, legal advice will be sought where appropriate, and on a case-by-case basis. The recommendations are then forwarded to the Independent Chair of the SAB for endorsement.

5.13 If the criteria for a statutory review (mandatory or discretionary) are not met, as endorsed by the Independent Chair, the SAR referral will be closed. Ordinarily, there will be no further action for the SAB. However, if it is considered that an action may be needed by the SAB, this will be taken forward outside of the SAR Protocol.

5.14 In the absence of an Independent Chair, the endorsement of the SAR Chair's recommendation for the outcome of a SAR referral, will be based on the agreement of the three Statutory Partners.

5.15 The Chair of the SAR Subgroup will formally notify the SAB's Independent Chair of the details of the case, context and recommendation (with reasons) of the SAR-Sub group to commence a SAR or not and any recommended actions that should then follow, including the proposed or recommended methodology.

5.16 If the decision is made to undertake a SAR, the SAB will make arrangements to notify partner agencies of the Board and other bodies as necessary. SAB Board Manager will also notify the BSAB Legal Adviser who will inform the Coroner's Office in line with

local protocols (This is in line with the 'Interface between SARs and Coronial Processes, Best Practice Guidance, which was shared by the National Business Manager Network, Sept 2024).

5.17 In the event that the SAR criteria are not met but single agency learning is identified. An internal review should take place, and the outcome of the single agency's actions should be reported at the next SAB meeting to provide assurance to the SAB of the learning which has been identified and completed within the agency.

Determining the Methodology:

5.18 The statutory duty enables wide discretion in the format and methodology used to review a case. Learning from the two national analysis of SARs[1] advocates identified that greater attention is needed to protected characteristics within safeguarding practice, as such particular care should be taken to ascertain information/data relevant to protected characteristics and SABs should actively consider how equality, diversity and inclusion issues will be addressed through the methodology and Terms of Reference (TOR).

5.19 It will be for the SAR Sub-group to determine the methodology according to a range of factors so that the process is proportionate and '*the focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or have been seriously abused or neglected*'. In line with findings from the national SAR analysis, the focus of the SAR should be on 'Why?' and relate this to national context where relevant. This may include a 'rapid review' as developed by SCIE. Best practice suggests that a range of different methodologies should be available. The SAR subgroup will need to consider the various options and decide which approach is likely to provide the most learning proportionate to the situation. All review methodologies outlined have some degree of flexibility. Key to this is agreeing the SAR TOR which could be agreed as draft and subsequently confirmed by the SAR subgroup or revised as appropriate with the SAR Panel and Independent Reviewer/Chair.

SAR Panel:

5.20 A SAR panel should be appointed to oversee the process, made up of senior representatives from agencies involved in the SAR and, if appropriate, also drawn from wider interested partners. A person who is independent of the case should be appointed as Chair. Consideration should be given to the appointment of an independent reviewer with suitable experience and expertise in safeguarding and quality assurance. The independent reviewer will need to provide assurance that they understand requirements of the General Data Protection Regulations and how it impacts on the retention of any information they will store in relation to the review. The

[1] Available at: https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

reviewer should be able to produce a SAR report which fulfils the TOR for the review and is compliant with the SAR SCIE Quality Markers.

5.21 In determining the methodology and key lines of enquiry within a review, the SAR panel should set out within the TOR prior learning and the existing evidential evidence base for good safeguarding practice. This should reference the impact that academic research, case law and both national and local SARs have had practice improvement. Consideration should also be given to whether the local area has other similar SARs which have identified the same or similar themes because the National Research makes reference to SABs have a tendency to 'start again' rather than considering subsequent reviews to ask the question what has (not) changed.

Appointing an Independent Reviewer:

5.22 Once the need for a SAR is confirmed, and the SAR Subgroup have agreed upon the most appropriate methodology to use for the case, the BSAB will consider a) a suitably skilled and experienced member of staff from an agency that is independent to lead the SAR, or b) commission an Independent Reviewer to lead the SAR and compile a formal report. BSAB will maintain a list of Independent Reviewers through Bolton Council's Procurement Framework. All Independent Reviewers (IR) must provide a career history that demonstrates they are not 'directly associated' with any of the agencies involved within the review and have a proven track record that evidences a fundamental knowledge and understanding of safeguarding in the context of safeguarding adults. Formal 'Expressions of Interest' will be sent to the IR list asking for initial written submissions of their suitability for the role, including fees, which will then form part of a shortlisting exercise. Successful candidates will be invited to interview with the SAB Board Manager and at least two of the Statutory Partners. The successful candidate, along with their credentials, will be shared with the Chair of the SAR Subgroup for ratification before entering into formal arrangements about contract and the SAR process.

5.23 The Independent Reviewer will:

- Attend a SAR Subgroup meeting to discuss the precise methodology and focus.
- Develop a draft TOR in conjunction with the SAR Panel.
- Ensure that SAR Panel meetings are arranged frequently and within appropriate timescales to ensure timely completion of the review.
- Liaise regularly with the SAB Board Manager to ensure the SAR Subgroup is fully sighted on the progress of the review and any problems/issues arising, particularly any ongoing investigations and any requests for extension to the timescale for submission of the final report.
- Liaise with family or significant others associated with case under direction of the SAR Panel and subject to ongoing criminal proceedings.
- Present the overview report to the SAR Subgroup for discussion and comment, before going to the BSAB for formal endorsement.
- Support a learning event and produce a briefing paper for wider learning for all organisations.

5.24 The formal procurement process and contract with the Independent Reviewer should clarify, among other issues, access to legal advice (if required), requirements for the reviewer to have suitable levels of insurance, detail expectations regarding compliance with data protection requirements and make reference to the SCIE SAR quality markers. Any TOR or contract of engagement should also require a SAR Independent Reviewer to report information to the SAB Chair where it appears the facts could give rise to liability issues, namely:

- civil liability, including negligence by a public body.
- criminal liability.
- regulatory enforcement issues.
- employment law issues in respect of a particular person or organisation
- potential human rights issues

5.25 The contract should also make clear that the SAR panel will be responsible for fact checking and quality assuring the final report in line with the SAR quality markers and with regards to the specific TOR. Family members should also be given an opportunity to meet with the Independent Reviewer to fact check the report and provide comments. Professionals involved in the case should report any factual inaccuracies or concerns to their relevant panel representative or, if their organisation is not represented on the SAR panel, to the Independent Reviewer and Panel Chair.

5.26 The contract should also set out how the Independent Reviewer would be expected to be involved in dispute resolution or complaint processes, particularly where these give rise to concerns regarding alleged breaches of obligations regarding personal information, negligent misstatements and defamation.

5.27 The contract should also clarify that whilst Independent Reviewers can use published materials freely, they should seek agreement from the SAB before disseminating information from unpublished reports (either within research papers or for any other means).

SAR Panel:

5.28 Panel membership shall be determined on a bespoke basis for each individual review, and as a minimum will be made up of the statutory safeguarding partners. The SAR Panel membership shall include both statutory and voluntary agencies, relevant to the circumstances of each individual case, ensuring that specialist agencies are represented, e.g. mental health. Panel members should be independent of the case and should not have line management responsibilities of practitioners that were directly involved.

5.29 The SAB Business Support team will write to the senior manager in each of the agencies identified as part of the scope of the review to request completion of an individual agency report and composite chronology. Information from the Agency reports will form part of the Overview Report. The aim of individual agency report is to look openly and critically at individual and organisational practice to see whether the

case indicates that changes could and should be made, and if so, to identify how those changes will be brought about. Agencies should ensure that an author is appointed to write the Agency report. In all cases the author should be a senior officer who is independent of the case and the practitioner. The agency's author should make this clear in their agency report and document their efforts to provide some independence into the process. The agency's author must have the relevant experience and sufficient time to complete the report; this may require the agency to relieve the author of existing duties temporarily.

5.30 Each agency report must include a conclusion with identified lessons the organisation has learnt from the review and the actions they have taken or intend to take to address them. They must have Senior Management oversight to ensure accountability.

5.31 The Independent Reviewer should conduct an 'Report Author Briefing session' and ensure that the methodology used addresses a systemic approach to identifying fundamental variables that shape frontline practice, in this way hindsight bias is prevented, and constructive reflection provides more opportunity for learning. The TOR from each review will inform organisations of the information required within the agency report.

5.32 Single agency reports are not shared beyond the individual SAR Panel and are treated as belonging to the organisation themselves. Any interested party such as the Coroner, IOPC, NHS England must make a direct disclosure request to each individual agency for their report(s) in the first instance.

5.33 The SAR Panel has the following functions and responsibilities:

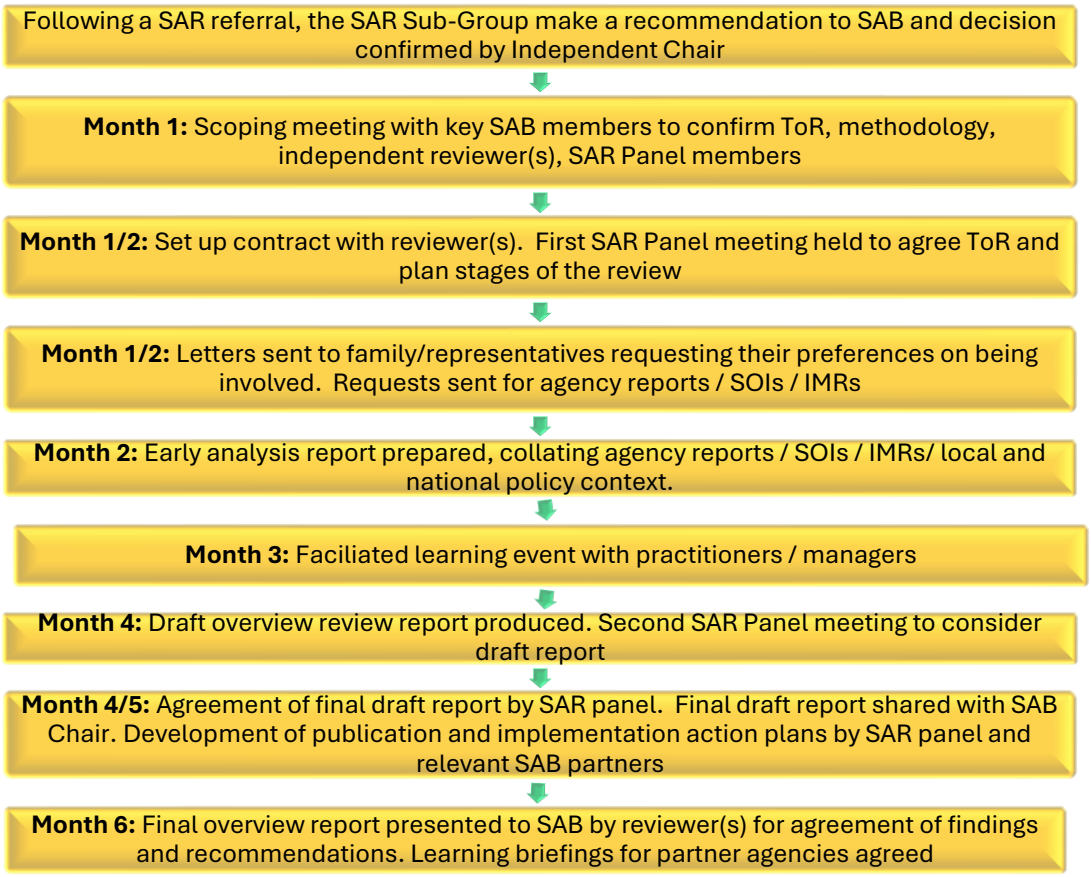
a. The SAR Panel in conjunction with the SAR-Subgroup should make the final decision on the suitability of the TOR for each SAR. Each set of TOR must include an insert upon the rationale of the chosen methodology of the case. A section on how the SAR will incorporate the six principles of safeguarding and a section on the Equality Act, 2010, and how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management, including recognition of unconscious bias, and how the learning from the review will be disseminated to local communities.
b. As information emerges, issues may need to be reconsidered, and this may in turn mean that the TOR will need to be revised and agreed by the SAR Panel and ratified by the SAR Subgroup.
c. Agree a single point of contact to ensure that family, friends and other support networks are included within the review process and ensure the person's anonymity is maintained in regard to any media attention.
d. Facilitate, via the BSAB Legal Adviser, engagement with the Crown Prosecution Service (CPS) and Coroner as required.
e. Ensure that it actively manages the process, seeking legal advice as necessary, so that the findings from other relevant processes such as Mental Health Investigations, criminal proceedings, Coroner's inquests, Child Safeguarding practice reviews, LeDeR Reviews or other parallel investigations are incorporated

into the overview report, where appropriate, reducing the cross over of investigations and duplication within reports.

f. Ensure that the overview report is of a high standard and is written in accordance with best practice guidance. The SAR Panel have a vital role in quality assuring all agency reports. The Panel must critically analyse and challenge the content, quality and accuracy of each agency report. They should provide direct feedback to both report authors and to those individuals responsible for quality assuring the final report on behalf of their organisation and, where necessary, make suggested additional recommendations to each agency. The report author checklist (Appendix – to be included) should be utilised to provide feedback.
g. The SAR Panel should ensure that the Overview Report and agency reports adheres to the prescribed SAR format and template).
h. Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the final Overview report, and that written copies are not shared with the family until finalised and approved by BSAB.
i. The SAR Panel should ensure that the Overview Report brings together and draws overall conclusions from the information and analysis contained in the agency information reports.
j. Agree the content of the Executive Summary and Overview Report which includes the action plan, ensuring that it is anonymised apart from the names of the Independent Reviewer and Panel members. Refer to the section under Publication and Communication.
k. Oversee the coordination of single agency action plans. Single agency action plans should be signed-off by a senior manager who will have accountability in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set out the means by which improvements in practice/ systems will be monitored and reviewed.
l. The Overview Report should make a small number of key recommendations for future action which the SAR Panel should ensure is in line with an outcomes-based accountability framework and translates into a specific, measurable, achievable, realistic and timely (SMART) action plan. The action plan should set out who will do what, by when, with what intended outcome. The action plan should set out how improvements in practice and systems will be monitored and reviewed. In the event of a disagreement the Independent Reviewer, will consult with the SAR Subgroup and Independent Chair of BSAB to resolve outstanding issues, and seek ratification of recommendations.
m. Clarify to whom in which organisations the executive summary and action plan should be made available to in order to support implementation of the recommendations and the learning of the lessons.
n. Throughout this process the SAR Panel will consider a communication strategy, linking with the SAR Subgroup as required. Where legal advice or guidance is required, this should be provided by the Legal Adviser to the Board and will be accessed via the Board Manager.

Timescales for a SAR:

5.34 There is an expectation in the Care Act 2014 that SARs are completed within 6 months. Below is a proposed project timeline for a SAR, but this is intended as a guide and will need to be adjusted to ensure cases are considered in a proportionate way to ensure necessary learning is achieved and equally allow sufficient time for family engagement in key parts of the process.



5.35 To ensure timeliness of the process and ensure that the Overview report is completed within six months of the date of the decision to proceed, unless an alternative timescale is formally agreed with BSAB. Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges that a SAR cannot be completed within the timescales, the SAR Panel should notify the Chair of the SAR Subgroup and Independent Chair of the BSAB to renegotiate the timescale for completion and notify the Coroner and relevant bodies for example (CQC, NHS England, IOPC) of any delays in completing the report. The Overview report must reference clear reasons for any delays, these may be positive/negative reasons for delay that has impacted on the process.

Involving the Adult and Family Members:

5.36 Whilst consent from the adult(s) and/or their family is not required for the SAR to go ahead, all adult(s) and family members or representatives involved in a SAR should

be given clear information about the SAR process so that they understand the purpose of a SAR and the specific scope that the review will consider.

5.37 The SAR TOR should specify any corresponding duties such as the police approach, in line with the Victim's Code, to provide family liaison. This may prove a useful starting point to avoid duplication or additional distress to families. Consideration should be given as to whether the adult and/or their family may benefit from the support of an advocate. In situations in which the adult(s) would have "substantial difficulty in participating themselves" and there is no other appropriate person to assist them, the local authority has a duty under the Care Act 2014 to involve an independent advocate. Reasonable support and adjustments should also be made as required to support the adult and/or their family/carers to participate in the SAR. This may include easy read/large print/translated documents, access to an interpreter, support from a chosen representative, longer meeting times, pre and post meeting briefings.

5.38 When considering engagement with family members and others, the SAR Panel should:

a. Consider who will contact the individuals or their family and support networks. This could be the Independent Reviewer or professional who knows the individual/family best. If two or more families are involved, there will need to be a clear, feasible plan for how the process will be managed, and an individual appointed contact for each respective family.
b. Nominated contact must ensure they provide opportunities throughout the SAR process to discuss any queries or clarifications about the SAR and maintain contact up until the publication of the review.
c. Consider the timing of such notification particularly when there are criminal justice processes running parallel. Decisions to make contact with significant others will need to be taken in consultation with relevant other agencies, for example, if the case is a criminal case a member of the SAR panel or the Board Manager must seek the advice of the Senior Investigating Officer prior to making contact with any significant others or family members. If there are parallel investigations, the Chair of the SAR Panel must contact agencies who have already been in touch with the person and/or family member, about their preferences in terms of communication, so that there is no further distress to the adult at risk or their families. Where there are Parallel reviews family engagement will be coordinated.
d. Consider how involvement will be sought, this may be by formal notification only, or by inviting them to share their views in a way which suits them.
e. The SAR panel must consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively. Consideration should also be given, if and how, a perpetrator might have some input to the review process.
f. If a decision is taken to not involve the adult or their family, the reasons why should be recorded along with any legal advice provided.
g. Ensure the Independent Reviewer of the SAR and a designated panel member meets with friends, family and others at the earliest opportunity, and offers

signposting to advocacy support services, for families that do not have a designated advocate.

h. Ensure consultation with the adult, friends and family is undertaken at every step of the SAR process, beginning with the TOR, the analysis of practice, constructing recommendations, and learning points through to the publication of the review and any follow up progress reports in the implementation of recommendations.
i. Agree and communicate through a single point of contact/designated advocate, where one has been assigned, who has, where possible, an existing working relationship with the individual and/or their family, for example a VCFSE representative.
j. The SAR Panel must maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the single point of contact/designated advocate when the review is completed and when the review has been ratified. Families, and significant others should also be informed about the potential consequences of publication, i.e., media attention and renewed interest in the SAR. The BSAB needs to ensure that the family are fully sighted and involved in any media statements on the publication of the review; consultation with the individual, family members and friends is integral to avoid sensitivities such as birthdays, anniversaries, etc. The SAR panel may need to consider if a risk assessment is required prior to publication.
k. If family/significant others prefer not to take part in the review, their decision will be respected. In either case, families/significant others, as identified by the SAR Panel, will be contacted to let them know that the review has been completed and be available to discuss its findings and recommendations at that time. This is particularly relevant for managing the communications strategy in advance of the publication of the report.

Responsibilities to, and Involvement of, Staff:

5.39 The death or serious injury of the individual(s) will have an impact on staff and indeed may be felt at a wider level within the organisation. As soon as a SAR has been agreed, any practitioners directly involved in the care and support of the individual(s) subject to a SAR should be notified of the decision to undertake the review by their agency. The purpose, process and circumstances of the review should be fully explained, and practitioners should be supported to take part by their agency. This should include support in relation to their health and wellbeing to minimise risks of their involvement causing distress.

5.40 All relevant practitioners should be given an opportunity to share their experiences and opinions on the case as appropriate to the methodology used. This should include their views about what they felt could have made a difference to the individual(s) and/or family. All agencies must encourage, and support practitioners involved in a SAR to be open and transparent in sharing their views, without fear of blame or reprisal, so that learning can take place.

Report and Recommendations:

5.41 The final SAR report "*should be written in plain and easy to understand language…. and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence*". The final report should contain:

- A sound analysis of what happened.
- Any errors or problematic practice and/or what could have been done differently.
- Why those errors or problematic practice occurred and/or why things were not done differently.
- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become system findings.

5.42 The SAR Panel should reviews the draft report to ensure a sufficient level of analysis, scrutiny and evaluation of evidence, before this is presented to the adult or their family, any relevant partners or organisations and the SAB. The final report will then be presented to the SAB, usually by the Independent Reviewer for final agreement.

Publication and Communication:

5.43 Publication and dissemination activities should be timely and publicise the key systemic risks identified through the SAR, as well as features supporting high reliability of single and multi-agency working relevant to safeguarding. Any published report should be fully anonymised.

5.44 Consideration should be given as to how to develop engaging means of circulating the findings, adapted as necessary for different operational and strategic audiences. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and other families; professionals who participated are kept informed and supported as needed. Publication and dissemination foster active responsibility and public accountability for addressing barriers identified to good practice or progressing improvement work.

5.45 The link to the published report and supporting tools will be shared with:

- Other Boards/Partnerships locally and across GM (if appropriate);
- Greater Manchester and National SAB Forums.
- Share with the National Database - if appropriate.

5.46 Published reports will be uploaded on to the Council's website and referenced in the BSAB annual report. In line with the Care Act, the annual report will include:

- The findings of the SAR.
- What actions have been taken (or will be taken) in relation to those findings.
- Where a recommendation has not been implemented, the reason/s for that decision.

5.47 A copy of the report should be provided to anyone who has requested it, particularly the adult (if they are alive), and their family (if involved in the SAR).

5.48 The SAR IR should take steps to ensure the adult (if they are alive) and their family understands the findings of the report and the recommendations it has made. A full copy of the report can only be shared with the family once this has been agreed by the BSAB Chair and following full sign-off.

5.49 Any media and communication issues will usually be coordinated by the Council's Communications Team. This will be done in collaboration with Communications Teams of other relevant agencies involved, alongside agreed representatives of the Board. The BSAB Chair will release a press statement where appropriate.

Implementation and Evaluation:

5.50 The real value of completion of a SAR is to ensure that the relevant learning has led to changes within organisational systems and in practice, so as to ensure safeguarding is improved and to prevent the issues in question happening again. The SAR subgroup will consider the recommendations from the report and agree an action plan. The development of an action plan may be delegated to a task and finish group or another SAB subgroup with representation from relevant agencies involved who will report progress back to the SAR or relevant subgroup.

The multi-agency action plan will include:

- The actions that are needed.
- Which agency and/or lead professional is responsible for specific actions.
- Timescales for completion of actions.
- The intended outcomes – what will change as a result?
- Mechanisms for monitoring and reviewing intended improvements.
- The processes for dissemination of the SAR report and/or its key findings.

5.51 The SAB will monitor progress on all recommendations and may request periodic progress update reports from partner agencies and relevant organisations (in line with statutory duties under s44(5) and s45 of the Care Act), until the time all actions are completed. Reports on the implementation of action plans across the partnership are usually presented to SAB meetings and must be published within the SAB's annual report.

5.52 Individual SAB members are responsible for ensuring that all actions for which their organisation is responsible are completed, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. Wherever possible, agencies should make every effort to capture learning points and take internal improvement action while the SAR is in progress, rather than waiting for the SAR report and action plan.

5.53 Sharing and embedding learning from SARs is a priority of the SAB. It is also reflected in the National Quality Board's position statement for Integrated Care Systems (ICSs)[2].

[2] The National Guidance on System Quality Groups sets out the importance of ensuring quality is the organising principle of ICSs and that this involves sharing learning and celebrating best practice.

SARs provide a rich source of learning to support continuous professional development as well as a significant evidence base which can help to develop a shared understanding of complex and often challenging areas of adult safeguarding practice. The SAB will usually produce learning briefings for all SARs to raise awareness of the key learning and to promote reflective discussions amongst front-line practitioners and managers within partner agencies. The SAB will also cascade learning through a variety of other mechanisms including multi-agency learning events, workshops and bitesize learning materials, such as podcasts and webinars.

5.54 SAB members who are responsible for training, commissioning and delivery within their organisations should lead on ensuring that learning from SARs is directly reflected within the content of their safeguarding training programmes. Care should be taken to ensure training materials focus on the learning from reviews and are not overtly critical of partners or individual practitioners as this can undermine partnerships and the overarching purpose of this process.

5.55 The SAB will ensure that there is a shared approach across the safeguarding partnerships, including the Safeguarding Children Partnership and the Community Safety Partnership to sharing learning emerging from SARs.

6. CROSS BORDER

6.1 There may be occasions where an adult is known to other areas. The initial SAR referral should be made to the local area where the adult has died. However, there may be occasions when the death of the adult or the serious incident has taken place outside the area to where they usually reside, and the adult is known to partners/services from a different area. In these circumstances there will need to be a discussion with the relevant SABs for a decision to be made which SAB is best to lead and/or consideration to be given whether the review process needs to be jointly led. When making a decision on which SAB should lead; the focus, ethos and rationale of the decision should be about which area(s) the potential learning relates to.

6.2 If the SAR referral relates to an adult who has experienced domestic abuse, controlling or coercive behaviour, or has children, it is good practice to inform the local Safeguarding Children Partnership and Community Safety Partnership to ensure transparency and connectivity.

6.3 Case examples to support decision making:

An adult with care and support needs has taken their own life on a railway in Trafford, but they lived and were supported by agencies and services within Bolton. The SAR referral has been sent to Trafford SAB.

Best Practice – Bolton SAB to take the lead in managing the referral/screening process due to the adult being known to Bolton services. Trafford SAB and/partner agencies will be given updates and be invited to participate in the decision making/review, if required.

An adult with care and support needs is remanded in prison located in Salford, prior to the sentence they were ordinary resident and supported by partners agencies and services from Bolton. **Best Practice - Bolton SAB should lead** because the adult is known to Bolton services prior to being remanded, therefore it's likely that the majority of the learning will relate to Bolton, however, Salford SAB should be kept updated and be invited to the review (if required).
If an adult with care and support needs is experiencing homelessness (either statutory or non-statutory duty is met), they are rough sleeping or have temporary accommodation in Manchester, but all support, and housing responsibility sits with Bolton. **Best Practice** - **Bolton SAB should lead.**
If an adult with care and support needs is living in an out of area placement in Stockport, commissioned by Bolton ASC and the placement has been made permanent, therefore all the services are provided by Stockport i.e., GP, District Nurses, therapist services etc. **Best Practice** - **Stockport should lead** on the screening of the referral but Bolton SAB and relevant partners should be invited to participate in the decision making (if required). If it's agreed that the criteria is met, the review should be led by Stockport SAB but consideration should be given to whether it is jointly funded by Bolton given the placement may still be funded by that Local Authority.

7. INTERFACE WITH SECTION 42 ENQUIRIES, OTHER REVIEWS AND PARALLEL PROCEEDINGS

7.1 In most cases a safeguarding process via a Section 42 enquiry will have been completed in relation to the circumstances of the case before a SAR referral is raised. It is important to note that a SAR is not an alternative to a safeguarding enquiry or other investigatory process, and as such will ordinarily only be considered following the conclusion of a statutory investigation (whether that be a police investigation, Section 42 safeguarding enquiry, or Patient Safety Incident (PSIT) report or equivalent undertaken by the NHS). However, there may be situations in which enquiries or investigations have not been completed, but the circumstances of the case necessitate that a SAR might be more effective than a Section 42 enquiry or other investigatory process. Decisions regarding this will be made on a case-by-case basis.

7.2 The SAR Subgroup will seek to identify from the outset whether there are any other investigatory proceedings or reviews taking place in relation to the same concerns. These may include:

- Criminal proceedings
- Coroner's inquests
- NHS Patient Safety Incident Response Framework (PSIRF) https://www.england.nhs.uk/patient-safety/incident-response-framework/
- Learning Disability Mortality Reviews (LeDeR) https://leder.nhs.uk/
- Child Safeguarding Practice Reviews https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel
- Domestic Homicide Reviews https://www.gov.uk/government/collections/domestic-homicide-review
- MAPPA Serious Case Reviews https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fassets.publi

shing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F1035787%2FMAPPA_Guidance_November_2021.odt&wdOrigin=BROWSELINK

- Mental Health Homicide Reviews or NHS Independent Investigation Reports https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/
- Fatal Fire Reports

7.3 Where there are parallel processes, the SAR TOR should outline how the process will dovetail with other relevant investigations to avoid, as much as possible, duplication of work, unnecessary delay and confusion to all parties, including the adult and/or their adult's family.

7.4 When a SAR referral overlaps with another review process there will be early liaison with the decision makers of those related review processes to determine how the reviews can be effectively managed and to avoid duplication, or decide which process should take precedence, or whether there are any opportunities for a joint review.

7.5 Where there are ongoing criminal investigations, court hearings or coroner's inquests the SAR Subgroup and Independent Chair will need to consider the potential impact a SAR may have upon such proceedings and whether the start of the review should be delayed until the completion of the proceedings. In such circumstances, legal advice should be sought, liaising with police, Coroner's Office, Crown Prosecution Service, if, and how the SAR should take account of these proceedings.

7.6 The Interface between SARs and Coronial Processes Best Practice Guidance[3] has been developed to support an effective interface between Safeguarding Adults Reviews (SARs) and Coronial Processes. The SAR Subgroup will refer to this guidance and the GM West Coroner's Protocol in their communications with the Coroner's Office and use templates as appropriate.

7.7 In relation to Coroner's proceedings, in situations in which the coroner's investigation identifies a concern that there is a risk of other deaths occurring in the future, the coroner will consider issuing a 'Prevention of Future Deaths' or 'Regulation 28' report, setting out the concerns and what action a person, body or organisation needs to take. All Regulation 28 notices should be notified to the BSAB so that any relevant single or multi-agency learning can be disseminated across partner agencies as appropriate.

7.8 Effective communication and joint working between the SAR Subgroup and the operational teams across the safeguarding partnership is critical in any cases involving parallel proceedings that have also been referred consideration of a SAR.

7.9 Organisations should use their own Serious Incident Reporting (SIR) to notify Chief Executives and the Directorate of any cases in which an adult known to their service has died or experienced serious harm as a result of abuse of neglect. It is important that the internal SIR process ensures any statutory considerations, such as making a SAR referral, are considered from the outset.

7.10 If there is a delay in the start or overall duration of the SAR as a consequence of a concurrent parallel process, a clear rationale will be recorded, and the SAR Subgroup will ensure that any identified learning at the earlier stages of the process is shared and taken forward with relevant parties.

[3] https://www.saeb.org.uk/wp-content/uploads/2024/11/National-SAB-Guidance-on-the-Interface-between-SARs-and-Coronial-Processes-22nd-July-2024-FINAL.pdf

7.11 If the SAR has explored the practice of a care provider regulated by the Care Quality Commission (CQC), a copy of the report should be provided to the CQC. Copies of any specific documentation or evidence submitted by the care provider as part of the SAR should also be provided to the CQC if it is requested.

8. USEFUL RESOURCES

8.1 The following resources provide additional information in relation to SARs and adult safeguarding:

- National Analysis of Safeguarding Adults Reviews
- SCIE SAR Quality Markers
- SCIE Guidance on SARs
- Sharing Information
- Users Involvement in Safeguarding https://www.scie.org.uk/publications/reports/report47/
- National SAB Guidance on Interface between SARs and Coronial Processes https://www.saeb.org.uk/wp-content/uploads/2024/11/National-SAB-Guidance-on-the-Interface-between-SARs-and-Coronial-Processes-22nd-July-2024-FINAL.pdf
- Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association
- Briefing for individuals and their families: Second national analysis of Safeguarding Adult Reviews | Local Government Association
- Care Act 2014