

Hull Safeguarding Adults Partnership Board

Safeguarding Adults Review Guidance

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1. Introduction

- 1.1 The Care Act 2014 requires Safeguarding Adult Boards (SAB) to arrange Safeguarding Adult Reviews (SARs), mandates when they must be arranged and gives SAB's flexibility to choose a proportionate methodology.
- 1.2 The purpose of a SAR is to identify learning and promote improvement action to prevent future deaths or serious harm occurring again. It is not the function of a SAR to reinvestigate incidents, apportion blame or hold any individual or organisation to account.

2. Criteria for a SAR

- 2.1 The Care Act 2014, Section 44, states;

(1) A Safeguarding Adults 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 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) condition 1 or 2 is 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.

(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) 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.

2.2 A SAR is a multi-agency process that is focused on learning and improving practice to develop services and prevent abuse and neglect in the future. It is not about blaming any agency, service or individual. Agencies will have their own internal procedures to review practice and raise standards, such as complaints, audits and serious incident investigations and a SAR is not intended to duplicate those processes, or to investigate allegations of abuse or neglect. Rather, the focus is on multi-agency learning by considering how agencies worked together, with the intention of improving how they do so in the future. This document sets out the criteria for conducting a SAR or other learning review and provides options for conducting those reviews.

2.3 The provision in Section 44(4) enables the HSAPB to commission a learning review of a case that has not met the SAR criteria but where it is clear that there is potential to identify sufficient and valuable learning. This is to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future. This may include;

- Serious incidents not meeting the criteria for a SAR
- Cases featuring repetitive or new concerns or issues which the SAB wants proactively to review to pre-emptively tackle practice areas or issues before serious abuse or neglect arises

- Cases featuring good practice in how agencies worked together to safeguarding and adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.
- 2.4 The SAR Panel is a sub-group of the Hull Safeguarding Adults Partnership Board (HSAPB). The Panel is responsible for managing the SAR process (or other learning review process) and assuring the HSAPB that recommendations and associated actions have been addressed.
- 2.5 The core group of the SAR Panel consists of the 3 statutory agencies:
- Adult Social Care, Hull City Council
 - Humberside Police
 - NHS Humber and North Yorkshire ICB
- 2.6 The SAR Panel is responsible for reviewing all SAR referrals and considering if the criteria for a mandatory SAR under S44 of the Care Act 2014 is met. If the criteria is not met the Panel will consider whether a Learning Review as per Section 44(4) is required.
- 2.7 The SAR Panel will record its rationale and recommendation on the SAR Panel Decision Log (Appendix D).
- 2.7 The Chair of the HSAPB will consider the recommendation of the SAR Panel and confirm whether the criteria for a SAR is met. They will endorse the HSAPB SAR Panel Decision Log with their comments and decision as to whether the recommendation of the SAR Panel is agreed.

3. SAR Referral process

- 3.1 Any individual or group who believe that a circumstance meets the SAR criteria as outlined in the Care Act (2014), should initially discuss the circumstances with their Adult Safeguarding Manager. When a referrer does not have access to an Adult Safeguarding Manager then an application can be made directly to the HSAPB Senior Safeguarding Officer.
- 3.2 The referral for a SAR should be made on the [HSAPB SAR Referral Form](#) (Appendix A). Once complete, the form should be submitted to the HSAPB Senior Safeguarding Officer via e mail; safeguardingadultsboard@hullcc.gov.uk
- 3.3 All referrals should be sent securely in line with the referrer's organisational policy.
- 3.4 On receipt of a referral the HSAPB Senior Safeguarding Officer will review the information and contact the referrer if it is identified that further details are required. Once a referral has sufficient information the Senior Safeguarding Officer will request Single Agency Management Reports from relevant agencies. Single Agency Management Reports are a summary of information held by relevant agencies on the person subject of the referral during a specified period.
- 3.5 Once all Single Agency Management Reports have been received, the Senior Safeguarding Officer will collate the information and provide a composite summary to the SAR Panel. This enables the Panel to assess the referral and make an informed decision as to whether the SAR criteria is met. If it determines the SAR criteria is not met it may agree an alternative form of learning review.

4. Decision Making for Conducting a Safeguarding Adults Review

- 4.1 The SAR Panel will consider the issues raised in the referral, the information supplied in the Single Agency Management Reports and whether the criteria for a SAR is met.
- 4.2 Throughout the SAR decision making process and any subsequent SAR or Learning Review cognisance should be given to the [Safeguarding Adults Review Quality Markers - SCIE](#)
- 4.3 The Chair of the SAR Panel will seek to identify at the outset what other reviews and processes are taking place or envisaged in relation to the referral. Possible connected processes include -
- Police investigation/criminal charges
 - Health and Safety Executive investigation/charges
 - Coroner's inquest
 - Local Child Safeguarding Practice Reviews
 - Domestic Abuse Related Death Reviews (DARDR)
- 4.6 There will be early liaison with the decision-maker in any related review process to determine how the reviews can be effectively managed to maximise learning for individuals and organisations, prevent duplication of investigative processes, and avoid confusion for families and professionals.
- 4.7 Consideration will be given to -
- Whether the actions of all agencies and all aspects of the case could be effectively covered by one review
 - Whether it would be appropriate for related reviews to be chaired by the same person
 - Whether some aspects of related reviews could be commissioned or undertaken jointly
 - Ensuring the terms of reference for related reviews effectively cover all aspects of the case
 - How to engage with adults, families and/or advocates to enable their involvement and contribution to a review
 - How to appropriately and sensitively manage family's expectations
- 4.8 The Learning Disabilities Mortality Review (LeDeR) Programme is outside of the SAR statutory duty but there may be cases where the circumstances of the incident meet the criteria for both. The SAR Panel will determine which is the most appropriate type of review. The LeDeR programme can be accessed [here](#)
- 4.9 Further information and guidance on whether a referral meets the SAR criteria can be found at Appendix B and here [HSAPB SAR Decision Process](#)
- 4.10 Further information on the process for gathering information with timescales and the decision making process can be found at Appendix C and here [Hull Safeguarding Adults - SAR](#)
- 4.11 The SAR Panel will record its decision and rationale on the HSAPB SAR Panel Decision Log (Appendix D).

- 4.12 If a mandatory SAR is agreed the HSAPB will commence the process to commission an independent author, or other appropriate reviewer (as per the decision by the HSAPB independent chair). The independent author with the HSAPB will determine;
- Which agencies should be asked to participate in the SAR or other form of learning review
 - Whether the agencies concerned are required to secure their files
 - Which methodology should be used to facilitate learning in the case
 - The Terms of Reference for the SAR
 - The required output from the SAR (e.g. a report)
 - The timescales for completion of the SAR. This should be within 6 months.
 - Recommendations relating to an independent facilitator/chair
 - Recommendations relating to the commissioning of an independent author
- 4.13 If the case does not meet the criteria for a SAR, the SAR panel will consider and decide whether it is still appropriate to undertake a learning review. If it feels there is value in such a review the Panel will decide what form this will take and which agencies are required to be involved.
- 4.14 The Chair of the HSAPB will consider the recommendation of the SAR Panel and confirm whether the criteria for a SAR is met. They will endorse the HSAPB SAR Panel Decision Log with their comments and decision as to whether the recommendation of the SAR Panel is agreed.

5. The Coroner

- 5.1 Coroners are independent judicial office holders. The role of the Coroner is to investigate deaths if they have reason to suspect that;
- The death was violent or unnatural; or
 - The cause of death is unknown; or
 - The deceased died while in state detention.
- 5.2 The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:
- Where there is an obvious and serious failing by one or more organisations
 - Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
 - Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home)
 - Deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.
- 5.3 Further information about the coronial process and the interface with SARs can be found [here](#).

6. Person, family and practitioner engagement

- 6.1 The HSAPB will ensure there is appropriate family involvement in the review process. Where possible this will include the victims of abuse and their families/significant others.
- 6.2 Every SAR is unique, and careful consideration must be given to the best method of communicating with and involving the adult, family, and friends. This will be led by the SAR chair/author.
- 6.3 When a SAR is to commence the Chair/author will write to the adult, a family member/friend/advocate informing them that the HSAPB is undertaking a SAR. Future communication methods and frequency will be determined on a case-by-case basis, and in consultation with family members.
- 6.4 An [information leaflet for families](#) has been developed and should be given to families to help them understand the SAR process and the role of the HSAPB

7. Safeguarding Adult Review Methodologies

- 7.1 Methodology is not prescribed in the Care Act, which provides flexibility to consider a range of options. The Care Act statutory guidance indicates that whichever SAR methodology is used, the following elements should be in place:
 - SAR chair – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience:
 - Strong leadership and ability to motivate others.
 - Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics.
 - Ability to use a range of investigatory techniques and methodologies.
 - Good analytical skills using qualitative data.
 - A participative and collaborative approach to problem solving
 - Adult safeguarding knowledge
 - Commitment to/promotion of open and reflective learning cultures.
 - SAR Panel – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review.
- 7.2 The SAR panel should consider which methodology and investigation tools are most appropriate for the review. It will often be most appropriate to collate chronologies, identifying key points and issues before deciding on the most appropriate methodology to use.
- 7.3 Regardless of which methodology is used, contributing agencies must be mindful of potential public scrutiny of the information they provide and, where necessary, seek legal advice prior to submission.

8. The SAR Report

- 8.1 The SAR Report brings together the learning and the themes identified during the SAR Process. It should provide analysis and comment on practice and the systems used to safeguard and promote the welfare of the adult
- 8.2 The key output is identifying learning and recommendations which can be developed into SMART action plans.
- 8.3 Once the SAR report is drafted it will be circulated to partners and attendees of the SAR meeting for comments and accuracy. Once comments have been received and the report updated (if necessary) it will be presented to the SAR Panel for final comments.
- 8.4 Family members and/or advocates should have the opportunity to discuss the report and conclusions, and their experience of the SAR process.
- 8.5 The report agreed by the SAR Panel will be presented to the HSAP Executive Board by the Head of Safeguarding Partnerships. The Executive Board will consider the report and, if in agreement, will ratify the report and close the SAR.
- 8.6 There is a statutory duty to publish the findings of SARs, however the method and extent of publication is not stipulated by the Care Act. Decisions concerning publication will consider the view of the Executive Board, the SAR Panel, the adult, family members and/ or advocates and any potential impact on those involved in the case.
- 8.7 Each organisation is responsible for internal communications with its employees who were involved in the case that the report and key findings are to be published.
- 8.8 SAR Report publication may be affected by parallel processes such as criminal proceedings/ court cases. Data sensitivity issues may also need to be considered as these may impact on individuals in the SAR. Whilst publication of the report may be delayed, the lessons learnt and recommendations can be actioned once the HSAPB Members have agreed the report.
- 8.9 Any publication of the report will be anonymised.
- 8.10 General themes and outcomes of SARs must be reported in the HSAPB Annual Report, with overviews and any resulting practice guidance/ resources for practitioners made available on the [HSAPB website](#).

9. After the SAR

- 9.1 The purpose of a SAR is to learn and improve practice and services. Development of a multi-agency action plan against the recommendations will be commissioned by the HSAPB.
- 9.2 The Head of Safeguarding Partnerships will consider the recommendations with the Chairs of the Learning from Reviews, and Quality Assurance sub-groups. They will collectively determine how best to deliver the recommendations, ensuring proper audit and monitoring processes are in place.
- 9.3 All recommendations following a SAR or other learning review will have a specific action setting out how learning will be disseminated and embedded. Learning from SAR's and other learning reviews will be disseminated and implemented in the following ways:

- Through the HSAPB Learning from Reviews sub-group
- Through the HSAPB Quality Assurance sub-group
- Through regular and specific Learning from Practice Events
- Annual Conference
- Review learning dissemination workshops
- By publication on the Hull Safeguarding Adults Partnership Board Website
- Through the HSAPB annual report, which highlights learning themes in both local and national reviews
- Through individual agency reviews
- Through the creation of HSAPB 7-minute briefings which will be circulated to partners to check accuracy, and then published on the HSAPB web site.

9.4 Progress against the recommendations, and exception reporting will be made by the respective sub-committee chairs to the HSAP Executive Board.

9.5 The HSAPB Senior Safeguarding officer will be responsible for creating and circulating summary reports/7-minute briefings where required. These will also be published on the [HSAPB website](#).

10. Timescales

10.1 SAR's must be completed in a timely manner. Once the decision to commission a Safeguarding Adults Review has been made, it should be completed and presented to the HSAPB within 6 months, unless agreed by the independent chair. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the independent chair.

10.2 It is acknowledged that where a SAR relates to serious institutional abuse or where multiple abusers are involved then such reviews are likely to be more complex and may require more time.

10.3 The Independent Author together with the SAR Chair must agree a timetable detailing milestones and deadlines for the review. Where timescales are at risk of not being met the HSAPB must be informed and an alternative timescale agreed.

10.4 Any learning identified at an early part of the review should be highlighted and action taken to implement it without waiting until the completion of the review.

11. Annual Report

11.1 One of the three core duties of HSAPB is to publish an annual report. The HSAPB annual report will refer to SAR's undertaken and any learning identified.

12. Information Sharing

12.1 This Safeguarding Adults Review Guidance should be viewed alongside Section 45 of The Care Act 2014, Supply of Information, and be fully compliant in those circumstances where information is required from other persons to enable the SAB to exercise its functions.

13. Professional Resolution/ Appeals

13.1 On occasions there will be a difference of professional views, particularly when practitioners are working together in the complex arena of safeguarding. When such instances arise the HSAPB [Safeguarding Adults Board and Safeguarding Children Partnership – Professional Resolution Practice Guidance](#) provides useful guidance. This proves a step-by-step escalation process for disagreements between professionals.

13.2 The National Network of Safeguarding Adults Board Chairs provides a [National Escalation Protocol for Issues from Safeguarding Adult Boards \(SABs\)](#).

13.3 The [Local Government Ombudsman](#) (LGO) has jurisdiction to investigate complaints about safeguarding investigations for which Councils have coordinating responsibility. Depending on the nature of the complaint, LGO's practice is to consider whether:

- the safeguarding investigation is proportionate
- the Council has taken appropriate action in response to the findings of the safeguarding investigation
- the Council continues to monitor the situation e.g. through its contracts and monitoring team or reviews
- the Council can provide evidence why the safeguarding allegations did not meet the safeguarding threshold
- there were any delays or other failures in the process
- the conclusions are consistent with the evidence
- the Council considered all relevant and available evidence.

13.3 Although safeguarding investigations are multi-agency in nature this does not preclude the LGO from investigating some matters that relate to the actions of professionals employed by organisations that do not fall within the LGO's jurisdiction. Further details of the distinction between Safeguarding Adults Boards and the LGO's jurisdiction are available at Appendix E.

13.4 Any requests made by the family or third-party representatives for documentation produced during the SAR process, will be initially referred to the Independent Chair, who will consider the request and allow dissemination if deemed appropriate.

Appendix A



Safeguarding Adult Review Referral Form

Hull Safeguarding Adults Partnership Board (HSAPB) Safeguarding Adult Review Panel (SAR Panel) considers a referral based on whether it meets the criteria for a Safeguarding Adult Review (SAR).

[Section 44 of the Care Act 2014](#) specifies when a SAR must be held.

Criteria for Conducting a SAR

A SAR is not restricted to occasions where the safeguarding procedures have been followed and can be applied where this has not been the case. Adoption of the SAR process will be relevant to

circumstances where inter-agency working practices have not served to effectively protect the adult(s) at risk from harm or the risk of serious harm.

The HSAPB will consider undertaking a SAR when it is known or suspected that:

(i) Actions or omissions in a number of agencies involved in the provision of care, support or safeguarding of an adult, or group of adults, at risk of abuse or neglect have caused or are implicated in the death or serious harm of that individual or group of individuals.

or

(ii) An adult or group of adults at risk die or experience serious harm and there are concerns about how agencies have worked together to prevent, identify, minimise or address that harm and there are concerns about how this may place other adults at risk of serious harm;

and

(iii) There are clearly identified areas of learning and practice improvement or service development that have the potential to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.

The SAR Panel will consider the issues raised and will examine the potential for learning across agencies/services. When a case meets the criteria for a SAR, the HSAPB SAR Panel will seek to identify what other reviews and processes are taking place or envisaged in relation to the same events, such as:

- Child Serious Case Review
- Domestic Homicide Review

There will be early liaison with the decision-maker in any related review process to determine how the reviews can be effectively managed to maximise learning for individuals and agencies, and to avoid duplication for families and professionals.

Consideration will be given to -

- Whether the actions of all agencies and all aspects of the case could be effectively covered by one of the reviews
- Whether it would be appropriate for related reviews to be chaired by the same person
- Whether some aspects of related reviews could be commissioned or undertaken jointly
- Ensuring that the terms of reference for related reviews effectively cover all aspects of the case

Early consideration will also be given to the way the SAR will take account of other possible connected processes, such as -

- Police investigation/criminal charges
- Health and Safety Executive investigation/charges
- Coroner's inquest

The SAR process does not replace any existing single agency internal review or process, complaint or legal process. These processes should continue as intended unless there is a clear rationale why the outcome of the SAR would affect this.

Consideration will also be given to how to engage with adults, families and/or advocates to enable involvement and contribution to reviews, and how their expectations can be managed appropriately and sensitively.

Completing this referral

Always use an appropriate confidential e mail system when sending the completed form.

Include only information which is known about the adult at risk and the alleged perpetrator (s). Do not make assumptions about either the adult at risk or the alleged perpetrator(s).

When describing the incident use factual details only. Describe the circumstances of the incident as you know them. Do not use overly emotive or critical language. Do not attempt to blame people or agencies for what you think may have caused the incident – the review is about looking at what happened to bring out any missed opportunities and the learning from these.

Use plain language that can be understood by someone with no prior knowledge of your agency and provide the meaning of any acronyms. Do not copy and paste extensive pieces of information from your agency's records and/or chronologies.

What are the care and support needs as identified in the Care Act 2014?

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified below:

1. Managing and maintaining nutrition
2. Maintaining personal hygiene
3. Managing toilet needs
4. Being appropriately clothed
5. Being able to make use of the adults home safely
6. Maintaining a habitable home environment
7. Developing and maintaining family or other personal relationship
8. Accessing and engaging in work, training, education, or volunteering
9. Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
10. Carrying out any caring responsibilities the adult has for a child

As a consequence, there is, or is likely to be, a significant impact on the adult's well-being.

If you have any questions, contact the HSAPB Senior Safeguarding Officer on 01482 615415 or safeguardingadultsboard@hullcc.gov.uk

Further information about Safeguarding Adult Reviews can be found on the HSAPB web site [Hull Safeguarding Adults Partnership Board - Policies and procedures – Hull Collaborative Partnership](#)

1.Rereferrer	
Name	
Job title	
Agency	
Address	
Telephone number	
Email address	
Role or relationship to adult in this referral	
Date of referral	

2.Senior Manager Authorisation	
Name	
Job title	
Telephone number	

Address	
Email address	
Date referral authorised	

3. Details of the adult subject of this referral	
Name	
Date of birth	
Address	
Has the adult died	Yes/No
Date of death (where applicable)	
Date of incident(s) if still alive	
GP name and address (if known)	
NHS number (if known)	
Details of any medical conditions (Physical and mental)	
Details of care and support needs	
Was the adult open to Adult Social Care?	Yes/No
Did the adult have a carer or advocate?	Yes/No

4. Details of the representative/family of the adult with care and support needs	
Does the adult have any family or representative?	Yes/No
Are they aware of the SAR referral?	Yes/No
Family member/representative contact name	
Relationship to the adult	
Address	
Telephone number	
E mail address	

5. Person(s) or Agency(s) Alleged Responsible to have Caused Harm or Neglect	
Name	
Agency	
Date of Birth (where applicable):	
Address:	
Relationship with adult (where applicable):	

6. How does this referral meet the SAR criteria?

Refer to the information at the start of this referral form for further details of what circumstances are likely to meet the criteria for a SAR.

<p>What type of abuse or neglect is the adult known or suspected to have suffered</p>	<input type="checkbox"/> Physical <input type="checkbox"/> Psychological or emotional <input type="checkbox"/> Financial <input type="checkbox"/> Domestic abuse <input type="checkbox"/> Neglect or acts of omission <input type="checkbox"/> Other Please specify)	<input type="checkbox"/> Sexual <input type="checkbox"/> Self-neglect <input type="checkbox"/> Modern slavery <input type="checkbox"/> Organisational <input type="checkbox"/> Discriminatory
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<p>Date of incident and cause of death (if applicable)</p> <p>Provide information as to why you know or have reason to suspect a direct causal link between the death or harm caused and an instance of abuse or neglect?</p>	
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<p>Did the adult have care and support needs?</p> <p>Care and support needs relate to help needed by an adult to manage and remain independent, arising from issues of learning or physical disability, mental illness or substance misuse. A care package does not need to be in place (Care Act 2014)</p> <p>Quick guide to eligibility outcomes under the Care Act 2014 - SCIE</p>	
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<p>Why you consider there to be concerns about the way in which several agencies worked together to safeguard the adult.</p> <p>Provide information that suggests the case has highlighted that several agencies have not worked together effectively to protect the adult. If only one sector or one agency's practice raises concern, then a single agency may be asked to undertake a review of the case.</p>	
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7. Investigations

Section 42 adult safeguarding enquiry?	Yes/No/Completed Outcome (if appropriate)
What other learning/review processes have been followed? If so: <ul style="list-style-type: none"> • What did they achieve? • How has the learning been disseminated? • What impact has it had? 	
Are there on-going criminal proceedings?	
Are any parallel processes ongoing?	
Other relevant information to support this referral	

8. Other Person(s) or Agency(s) believed to have been involved with the adult.

9. If relevant provide details why this case may attract media attention

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10. Other supporting information

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11. Protected Characteristics (leave blank if not known)

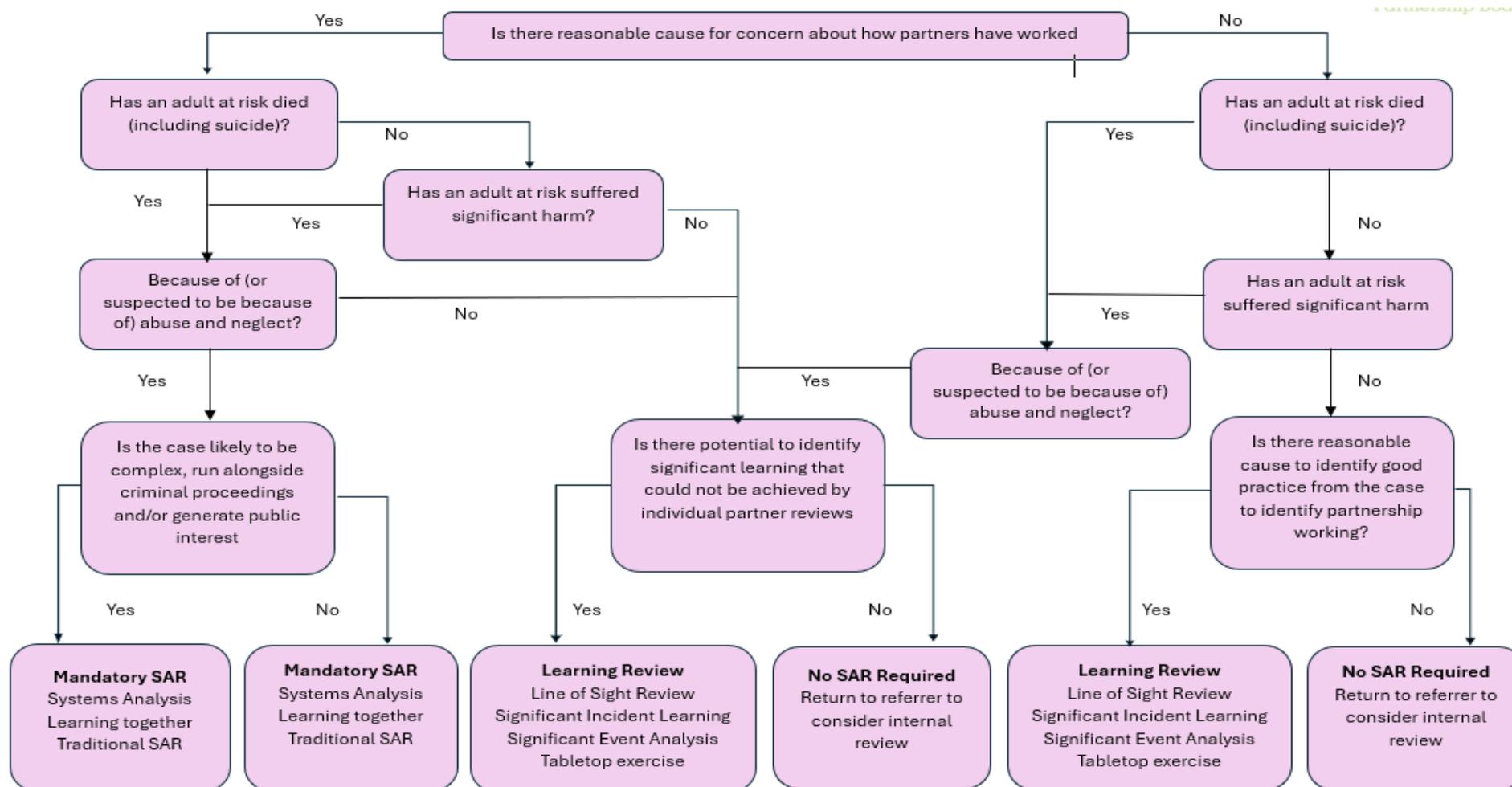
Age	
Disability <ul style="list-style-type: none"> • Physical or mental health condition lasting 12 months or more 	
Gender <ul style="list-style-type: none"> • Female • Male 	

<p>Sexual orientation</p> <ul style="list-style-type: none"> • Straight (heterosexual) • Bisexual • Gay/Lesbian (homosexual) • Other sexual orientation (please write in) 	
<p>Ethnic group</p> <ul style="list-style-type: none"> • White (British, Irish, any other white background) • Asian/Asian British (Indian, Pakistani, Bangladeshi) • Black/African/Caribbean/Black British • Arab • Chinese • Gypsy, Roma or Traveller • Mixed/Multiple ethnicities • Other ethnic group 	
<p>Relationship status</p> <ul style="list-style-type: none"> • Single • Married • In a registered civil partnership • Separated, but still legally married • Separated, but still legally in a civil partnership • Divorced • Formerly in a civil partnership which is now legally dissolved • Widowed • Surviving partner from a registered civil partnership • Cohabiting 	
<p>Religion or Belief</p> <ul style="list-style-type: none"> • No religion • Christian (including Church of England, Catholic, Protestant and all other Christian denominations) • Buddhist • Hindu • Jewish • Muslim • Sikh • Any other religion, write in (please write in) 	
<p>Pregnancy and Parenthood</p> <ul style="list-style-type: none"> • Pregnant or given birth in preceding 26 weeks • Breastfeeding 	
<p>Gender Reassignment</p> <ul style="list-style-type: none"> • Is the person proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex. 	

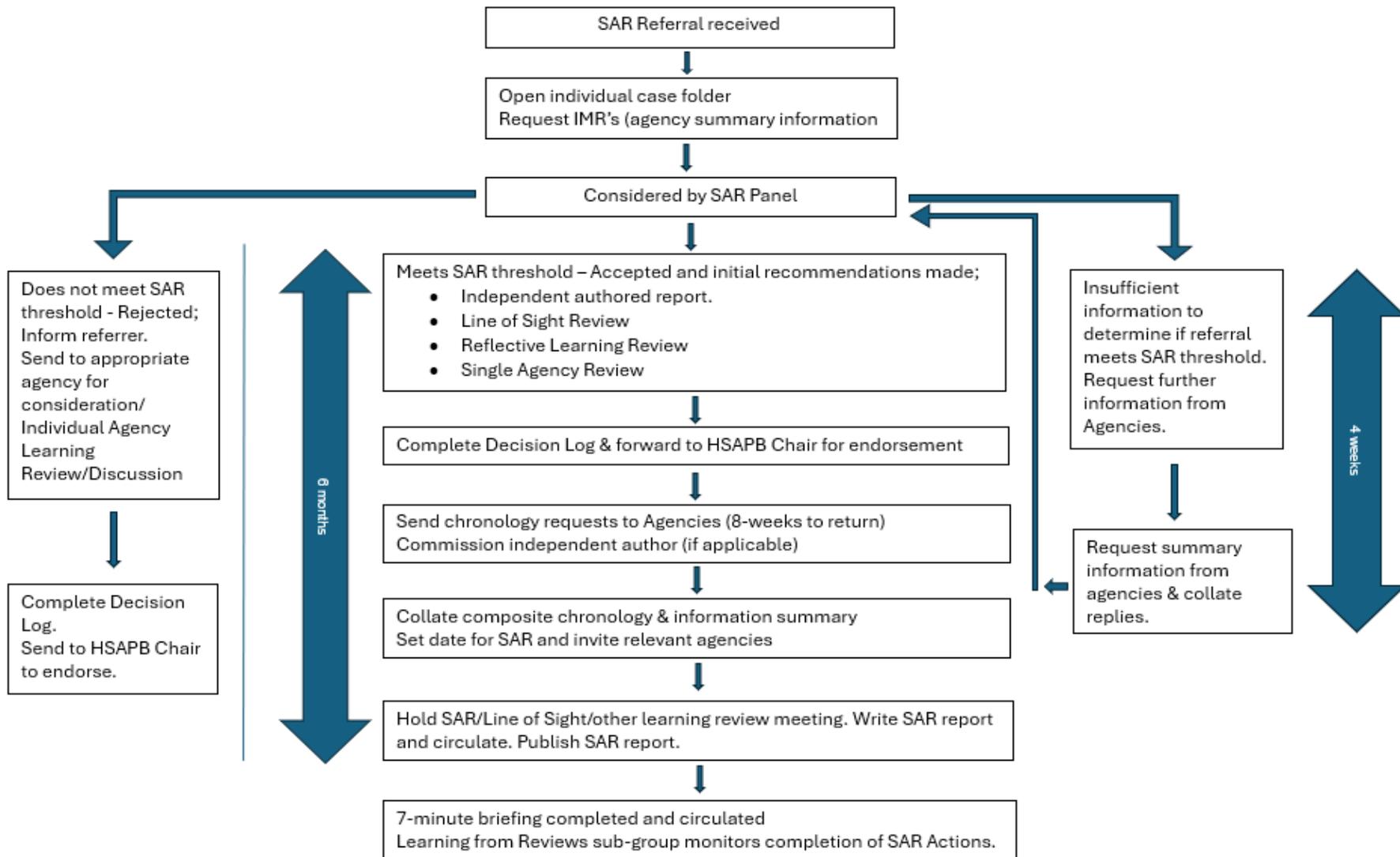
11. Referrer signature	
Signature:	
Date:	

When completed, e mail this form to the HSAPB Senior Safeguarding Officer safeguardingadultsboard@hullcc.gov.uk

Appendix B



Appendix C



Appendix D

HSAPB Safeguarding Adult Review Decision Log

Purpose of a Safeguarding Adult Review (SAR)

The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, and about the way in which local professionals and agencies worked together to safeguard the adult at risk.

The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for future practice.

The purpose of the SAR is to:

- Determine what might have been done differently to prevent the harm or death
- Identify lessons and apply these to prevent a recurrence
- Review the effectiveness of multi-agency safeguarding arrangements
- Inform and improve future practice and partnership working
- Highlight good practice

If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. Serious Incident Requiring Investigation, Critical Incident Review), this should take place without delay and in line with the organisation's internal policy requirements.

Learning reviews

The statutory guidance to the Care Act (2014) clarifies that Safeguarding Adult Boards (SAB's) are free to arrange SARs in other situations involving an adult in its area with needs for care and support:

- The SAB must consider what type of review will promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
- This can include cases providing useful insights into the way organisations are working together to prevent and reduce abuse and neglect.
- This can be used to explore examples of good practice where this will highlight action that can be applied to future cases.

Cases not meeting the SAR criteria may be reviewed using other methods including reflective workshops, table-top exercises and partnership reviews.

Criteria for conducting a SAR

The SAB must arrange a SAR of a case of an adult with care and support needs in its area (whether or not the local authority was meeting those needs) if;

- a) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult
and
- b) The person died and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)
or
- c) The person is still alive, but the Safeguarding Adults Board knows or suspects they've experienced serious abuse/neglect, sustained potentially life-threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

Adult in SAR referral			
Name			
Date of birth		Date of death	
Cause of death		Time period under consideration	
Summary of referral			

SAR Panel		
SAR Panel Date		
The following decision-making criteria is used to assess all SAR referrals:		
	Yes/No	Comments
1. Do the concerns relate to a person with care and support needs – whether or not in receipt of services at the time of death or injury?		
2. Has the cause of death been established?		
3. Has any safeguarding enquiry process concluded?		
4. Is there evidence of a causal link between the death and abuse, neglect or acts of omission?		
5. Is the harm caused or death judged to have been preventable?		
6. Do concerns exist about the way partners worked together to safeguard the adult?		
7. Do the concerns relate to <u>systemic</u> failings relating to <u>multiple</u> organisations?		
8. Is there potential to identify learning to improve the local safeguarding system, multi-agency practice and partnership working?		
9. Will the SAR add value to any investigations or reviews already carried out and not duplicate?		

Criteria for conducting a SAR and Decision		
Mandatory SAR	Yes/No	Comments
Is there evidence of the adult having care and support needs?	Guidance – care and support needs relate to help needed by an adult to manage and remain independent, arising from issues of <u>learning or physical disability, mental illness or substance misuse.</u> A care package does not need to be in place (Care Act 2014).	
AND		
Is there reasonable cause for concern about how the services have worked together to safeguard the adult	Guidance – consider if the case has highlighted that <u>several agencies have not worked together effectively to protect the adult.</u> If only one sector or one agency’s practice raises concern, then a single agency may be asked to undertake a review of the case.	
AND		
If the adult died, do we know or suspect that the death resulted from abuse or neglect? (Care Act 2014, section 44, 2)	Guidance – we need reason to know or suspect a <u>direct causal link between the death and an instance of abuse or neglect.</u> Categories of abuse and neglect: <ul style="list-style-type: none"> • physical abuse • domestic abuse • sexual abuse • psychological abuse • discriminatory abuse • organisational abuse • neglect and acts of omission • self-neglect • financial abuse 	
OR		
If the adult is alive, do we know or suspect that they experienced serious abuse or neglect? (Section 44, 3)	Guidance - Serious abuse equates to the adult having been likely to have <u>died but for an intervention</u> or <u>having suffered permanent harm</u> or <u>reduced capacity of quality</u>	

	of life as a result of the abuse or neglect.		
Learning Review		Learning focus and strategic reason for commissioning	
Any other case of an adult with care and support needs (Section 44, 4)	Guidance - Irrespective of whether the LA has been meeting any of those needs. Allows flexibility for the HSAPB to undertake learning review activity where they are aware that there are <u>weaknesses (or strengths) in the safeguarding system that need to be better understood.</u>		
Mandatory SAR criteria met	Yes/No		
Methodology for SAR (if criteria met)			
What should the TOR focus on?			
If criteria is not met is any other type of learning review/ event required?			
Rational for decision & what the review should focus on			

HSAPB Independent Chair Comments

Signature		Date	

HSAPB Executive Board Comments			
Organisation	Name	Signature	Date
Humberside Police			
Hull City Council			
NHS Humber and North Yorkshire Integrated Care Board			

Appendix E

Safeguarding Adults Boards and the LGO's jurisdiction

Example of complaint	Could the LGO investigate?	Rationale
1. Complainant disagrees with SAB decision to not undertake a safeguarding adults review	Yes	Councils have overall Coordinating responsibility for SABs and for ensuring there are appropriate multi-agency policies in place. There should be policies about the circumstances in which a serious care review should be carried out. However, this may come down to merits.
2. Complainant is unhappy with the conduct or decision-making of the Independent Chair	Yes	The Independent Chair is appointed by the Council (requirement under No Secrets; optional under Care Act) so can be considered an administrative function of the Council. We could consider the process for selection and the suitability. The decision making of the Chair may come down to merits.
3. Complainant unhappy with decision of a SAB or outcome of a safeguarding adults review	Yes	As Councils have coordinating responsibility, the decisions taken by SABs would fall under the Council's administrative functions. Again, the decision may come down to merits.
4. Complainant is unhappy with a decision reached by a SAB because of the actions or omissions of a professional on the SAB, who is employed by a body that falls outside the LGO's jurisdiction	Potentially (but we would not investigate the conduct of these individuals – see 13)	<p>If the complainant alleges that the actions or omissions led to the wrong decision by the SAB the LGO can consider any failures by the SAB in the evidence gathering or decision making stages and whether those failures materially affected the outcome. Under the Care Act councils are responsible for ensuring the members of the SAB are sufficiently skilled and experienced to perform their roles.</p> <p>Examples could be failure to interview key people or failure to undertake a proper assessment, or the sharing of inaccurate or incomplete information.</p>

5. Complainant alleges the SAB has not followed its own policies and procedures.	Yes – assuming the complainant is claiming significant injustice	Councils are responsible for setting up and coordinating SABs. Such complaint would be considered an administrative function of a Council.
6. Complainant unhappy with the length of time taken by an SAB to conclude a case.	Yes	As above.
7. Complainant says SAB failed to take account of all relevant evidence (including failure to involve the vulnerable adult/representative).	Yes	As above.
8. Lack of administrative support to SAB/SAR	Yes – assuming the complainant is claiming significant injustice	Council have the lead responsibility for the setting up and conduct of SAB/SAR
9. Complaint is about the makeup of the SAR and potential conflict of interest	Yes	As above
10. Chair of the SAB is also the chair of the SAR	Yes	We can investigate this in terms of conflict of interests. But in principle there is no reason why the chair of the SAB cannot be the chair of the SAR
11. Not sharing the Terms of Reference of the SAR with the representatives	Yes	Whilst SARs are usually convened because of the death of an individual, we could look at how information was shared with reps/family members
12. Complainant says a body that falls outside the LGO's jurisdiction failed to provide the necessary evidence to a SAB.	Potentially/in part	Complainant will probably need to address this issue with the relevant organisation. However, under the Care Act there is a duty on relevant organisations to share any evidence requested by a SAB that is relevant to the SAB's function. We could potentially investigate whether the SAB took sufficient steps to obtain the evidence and

		inform the organisation of its duty to share information. However, the LGO role would be very limited in such cases.
13. Complainant is unhappy with the conduct of a professional on a SAB who is employed by a body that falls outside the LGO's jurisdiction	No	The complainant should address their concerns to the relevant organisation or professional body that regulates the particular profession. This could include an individual's behaviour (e.g. attitude or rudeness).
14. Complainant is unhappy with a decision taken by a professional/organisation that does not fall within the LGO's jurisdiction e.g. the Police decide not to pursue a criminal investigation; NHS decides not to provide specific medical treatment.	No	These decisions do not relate to the functions of an SAB or a Council and therefore are outside the LGO's jurisdiction to investigate. The complainant will need to raise their concerns with the relevant organisation.