SAFEGUARDING ADULTS REVIEW

POLICY AND PROCEDURE

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PART 1: Safeguarding Adults Review Policy

1. Introduction:

This policy and procedures document has been mapped against the Social Care Institute for Excellence's (SCIE) SAR Quality Markers (QMs). Where the document supports the quality markers this is shown in the following way: [QMX]. SAR Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs. The Quality Markers are based on statutory requirements, established principles of effective reviews and incident investigations, as well as practice experience and ethical considerations.

2. Purpose

2.1. The purpose of a SAR is to allow professionals, organisations, and agencies to positively learn lessons which surface, consider the strengths and difficulties in safeguarding practice, inform and guide further improvement activity [QM 4.2.1]. It looks at what agencies and individuals might have been done differently that could have prevented harm or death so that these lessons can be learned and applied to future practice to prevent similar harm occurring again.

2.2. Its purpose is not to hold any individual or organisation to account, not to re-investigate or to apportion blame. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as Care Quality Commission (CQC), the Nursing and Midwifery Council, Social Work England, the Health and Care Professions Council, and the General Medical Council.

3. Criteria for a SAR

3.1. Under the Section 44 of the Care Act 2014, there are three broad circumstances which considers when a SAR should take place. The legislation makes a distinction between those circumstances where the SAB **must (mandatory)** or **may (discretionary)** arrange a SAR both of which are statutory reviews.

Mandatory SAR Criteria

Section 44 of the Care Act 2014 states:

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

*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 SAR Criteria

Section 44 of the Care Act 2014 also states:

4) An 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).

3.2. 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 –

1) Identifying the lessons to be learnt from the adult's case, and

2) Applying those lessons to future cases.

3.3. It is important to note that, if the nature of the incident triggers a mandatory investigation or review within the organisation concerned e.g. NHS Patient Safety Incident Response Framework (PSIRF), this should take place **without delay** and in line with the organisation's internal policy requirements. Internal governance processes and SARs are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes.

4. Identification and Referral of Safeguarding Adults Review

4.1. The SAB is the only body which can arrange / commission a Safeguarding Adults Review. Where any agency representative / professional including local councillors, Members of Parliament, and Coroner, think the criteria for a case is met, they must complete a safeguarding adults review referral form, Appendix A, which can be found on the Safeguarding Board website. Safeguarding Adults Reviews | Cambridgeshire and Peterborough Safeguarding Partnership Board

4.2. For those making a SAR referral from an agency represented at the Safeguarding Adults Review subgroup, the relevant subgroup member must review the referral before it is submitted to ensure the referral is complete, and it is of the necessary quality.

4.3. If a member of the public, including the adult themselves, wishes to make a referral for a Safeguarding Adults Review, they should contact a professional involved with the adult's care to discuss the situation, and if deemed appropriate, the worker should make a referral.

4.4. Completed referrals must be submitted to the SAB business unit (safeguardingboards@cambridgeshire.gov.uk) using the template at Appendix A where the Business Unit will acknowledge receipt of the referral and inform the Independent SAR Chair.

4.5. If the referral is found to be incomplete or of poor quality, the referral will be returned to the referrer with advice. The quality check is to ensure that all the necessary information has been included and that the information given has been done in such a way which the SAR Consideration Panel can use in its decision-making process. [QM1.2.2 to 1.2.5].

4.6. Once the SAR referral has passed the quality check, the business unit will share the referral with the Independent Chair of the SAR Subgroup, for information. The Board business unit will then establish which partner agencies have been involved with the individual(s), to request they complete a summary of involvement template Appendix B. Agencies are required to submit their completed summary of agency involvement forms, to the business unit.

4.7. Agencies do not need to include events that would be unrelated to decision making about a SAR. What is required is a summary of the agency's involvement, based on their review of the relevant documentation held by their organisation. This should not be an onerous exercise but a high-level review of the case, identifying specific concerns about multi-agency working.

4.8. Every effort will be made to make decisions on a referral within 45 days. However, it is acknowledged that this may be impacted by a number of factors outside of the SAR Subgroup's control including delays in receiving information from partner agencies. Reasons for any delay in decision-making process will be recorded in the meeting minutes [QM 2.1.9, QM 2.2.9 & QM 6.1.1(ii)]

4.9. **PLEASE NOTE:** Whilst it is good practice to discuss a SAR referral with family members, it is not a requirement. If the SAR referral has been discussed with family members it is the referrer's responsibility and not the responsibility of SAB Business Unit to inform the family of the outcome at SAR referral. [QM 3.1.1].

5. Information Governance

Section 45 of the Care Act 2014 also states:

1) If an SAB requests a person to supply information to it, or to some other person specified in the request, the person to whom the request is made must comply with the request if—
   (a) conditions 1 and 2 are met, and
   (b) condition 3 or 4 is met.

2) Condition 1 is that the request is made for the purpose of enabling or assisting the SAB to exercise its functions.

3) Condition 2 is that the request is made to a person whose functions or activities the SAB considers to be such that the person is likely to have information relevant to the exercise of a function by the SAB.

4) Condition 3 is that the information relates to—
   (a) the person to whom the request is made,
   (b) a function or activity of that person, or
   (c) a person in respect of whom that person exercises a function or engages in an activity.

5) Condition 4 is that the information—
   (a) is information requested by the SAB from a person to whom information was supplied in compliance with another request under this section, and
   (b) is the same as, or is derived from, information so supplied.

6) Information may be used by the SAB, or other person to whom it is supplied under subsection (1), only for the purpose of enabling or assisting the SAB to exercise its functions.

5.1. Section 45 of the Care Act places a legal duty on organisations to comply with requests for information that are received from Safeguarding Adults Boards that may assist with SARs. Organisations are required to give due consideration to the Data Protection Act 2018 and General Data Protection Regulations, but this should not be used as a reason to withhold information.

5.2. Once it is known that a SAR referral has been received, agencies involved should, where possible, secure case records to guard against loss or interference, whilst still enabling their professional duty to be carried out. All agencies also have a responsibility for promoting confidentiality and sensitivity in the co-ordination and management of the SAR process. All reports and information used as part of the SAR process must indicate their confidential nature and be securely shared in accordance with each agency's information governance procedures.

5.3. No sensitive or person identifiable information should be shared with any person or agency that is unlikely to hold relevant information. Anyone receiving a request to check records and find that nothing is held must advise the Safeguarding Board's Business Unit accordingly about this and then immediately delete the request and or any associated emails.

Freedom of Information Act 2000 (FOIA)

5.4. As a general rule, agencies involved in a SAR deal with individual requests under the FOIA in accordance with their own procedures, as SABs are not a 'public authority' as set out under the Schedule to the Act and are therefore exempt from requests for disclosures of information. Only information that has voluntarily been made public or is accessible under other legislation (e.g., Data Protection Act) will be available to others.

Records and retention

5.5. The Safeguarding Board's Business Unit is responsible for all SAR referrals and subsequent review related documents, which will be stored in a secure electronic folder. Material received through the SAR process is third party material and belongs to the agency who supplied it; any requests for information must be directed to the individual agency. Material will be retained for a maximum of seven years following the publication of the SAR in line with the SAB Retention Schedule and then deleted.

6. Decision Making on SAR Referrals

6.1. The SAR referral will be presented by the referring agency to the SAR Subgroup's monthly Consideration Panel. This meeting will be chaired by the SAR Subgroup Independent Chair, and must comprise of at least 1 representative from Cambridgeshire Constabulary, NHS Cambridgeshire and Peterborough Integrated Care Board, and Adult Social Care (from the originating local authority). There should also be a representative from each of the agencies who have had involvement with the adult.

6.2. Attendees will present scoping information from their agency and the chair will present information from agencies not in attendance.

6.3. The Consideration Panel will establish if there were gaps in multi-agency working and consider whether there is a mandatory obligation to undertake a SAR, using the criteria outlined in **section 3** above.

6.4. To support this decision-making process, Consideration Panel members may use the SAR Referral Decision Making Template [QM 2.2.1 to 2.2.8, 2.2.11, 2.2.13 to 2.2.16, 2.4.1 to 2.4.4].

6.5. The SAB may also comission reviews in any other situations involving adults with care and support needs (whether or not the local authority has been meeting any of those needs) under Section 44(4). While such reviews are at the discretion of the SAB, these reviews are statutory. [QM 2.2.10]

6.6. Should the consideration panel agree that a referral does not meet the criteria, but considers there to be single agency learning, they can recommend that the relevant agency conduct an internal review. At the end of the review, the agency will be asked to share relevant findings with the SAR Subgroup.

6.7. Following the consideration panel, the Independent Chair will complete the decision making form which will be sent to the SAB Chair to agree the recommendation on behalf of the SAB.

7. SAR Methodology

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. 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 been seriously abused or neglected.
Care and Support Statutory Guidance – paragraph 14.170

7.1. SARs can be conducted in a variety of ways and no one model will be applicable for all cases. The methodology selected must offer the most effective learning and involvement of key staff / family weighed against the cost, resources and length of time required to conduct the review [QM 5.1.1].

7.2. The following should be considered in selecting a SAR methodology:

1) Is the case complex, involving multiple abuse types and/or victims?
2) Is significant public interest in the review anticipated?
3) Is large-scale staff/family involvement wanted/ appropriate?
4) Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
5) Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined [QM 5.2.10]?
6) Is the precise form and focus best suited to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities to the benefit of adults and their families?
7) What is the quickest and simplest way to achieve the learning [QM 5.2.7]?
8) Is there an opportunity for thematic learning - has a similar review been conducted before? Is there any useful recommendations or reports within the national SAR library? [QM 5.2.8]?
9) Is a more appreciative approach required to review good practice?
10) Are trained lead reviewers available in-house or nationally for the method selected?
11) Can value for money be demonstrated?

7.3. Irrespective of the methodology chosen, all reviews should apply the following principles:

1) A culture of continuous learning and improvement across the organisations involved and to promote the wellbeing and empowerment of adults at risk; identifying opportunities to draw on what works well, and promoting good practice
2) Approach to be proportionate to the scale and level of complexity of the issues

being examined.

7.4. The SAR Subgroup/Consideration Panel/SAR Panel will endorse the approach best suited and proportionate to the circumstances for each individual case. Models include but not limited to:

1) 'Traditional' SAR
2) SAR in Rapid Time
3) Practitioner / Significant Event Analysis
4) Appreciative Enquiry
5) Thematic Review
6) Peer Review
7) Multi-Agency combined Chronology

7.5. This is not a prescriptive or exhaustive list but offers a range of options that could be matched to different presenting circumstances. Alternatives, based upon the collective experience of the SAR Subgroup and Independent Reviewer should also be considered as appropriate. The methodology chosen should seek to build upon the findings from previous local SARs.

7.6. More details on different types of methodology can be found in Appendix 7.

8. Legal advice

8.1. Legal advice will be supplied by the relevant Local Authority's legal representative in the first instance, unless a conflict of interest should arise, in which case independent legal advice will be sought, or legal advice from the individual organisation who may be the subject of any concern. [QM 2.1.8. 4.1.4, 14.2.2-3-4]

9. Allegations of misconduct

9.1. SARs do not explore whether an organisation or individual is responsible for breaches in criminal, disciplinary and regulatory processes, set outside or within individual organisations. Where relevant, additional investigations will commence prior to, or parallel with, the SAR.

9.2. If an issue of this nature arises, the relevant organisation will be notified by the SAB via the Business Unit's Business Manager/Head of Service and after consulting with the Independent Chair. Should information regarding significant, individual and/or organisational omission be received that requires notification to a statutory body, SAB or another relevant agency will ensure this is completed without delay.

10. Dispute Resolution during SAR Process

10.1. It is recognised that disputes may arise at any stage during the SAR process, including whether a SAR should be commissioned, how it is commissioned and any aspect of the outcome of the review, including the content of the report.

10.2. A dispute may arise because of a disagreement or complaint from anyone involved in the SAR process [QM 4.1.2, 7.1.1].

10.3. The SAB retains ultimate responsibility for the SAR process. Where a dispute arises, it shall be dealt with as follows [QM 6.2.5]:

1) Those responsible for the relevant part of the SAR process shall attempt to resolve any dispute by consensus. Examples of disputes could include, within the SARG Consideration Panel about whether or not a SAR should be commissioned, for the SAR panel during the carrying out of the review on the interpretation of information or evidence.

2) For agencies on the SAR Panel, the objecting party will provide written representation setting out their concerns to the SARG Independent SAR Chair within seven working days of being advised that the final draft report will not be amended.

3) The representations of the panel member and the Independent Reviewer will be considered by the Independent SAR Subgroup Chair. Where the Independent SAR Subgroup Chair is unable to resolve the dispute, they may recommend review by the Independent SAB Chair. It may be recommended that a reference to the dispute, and that it was not possible to resolve it, should be included as a footnote to the report.

PART 2: Safeguarding Adults Review Procedure

Please note that more than one stage may be happening at the same time.

1. Stage 1: Appoint an Independent Report Writer (IRW)

1.1. Once a decision has been made to commission a Safeguarding Adults Review, the appointment of an Independent Reviewer will be made via a request for expression of interest through all appropriate networks, including the National SAR Reviewers Network.

1.2. If, following the Consideration Panel's decision to commission a SAR, a preferred metholdology is agreed, the methodology will be included in the request for expressions of interest.

1.3. The selection of the Independent Reviewer will be made using the criteria and checklist as set out in **Appendix 6**, including a declaration that the reviewer does not hold any conflicts of interest in accepting the appointment [QM 2.1.3, QM 5.3.4]. Should a conflict of interest arise during the process of the review, the Independent Reviewer must delcare this at the earliest opportunity to the Business Unit.

1.4. The Independent Reviewer will have appropriate skills and experience which should include:

1) Strong leadership and ability to motivate others ensuring parties have a shared understanding regarding the purpose of the SAR

2) Expert facilitation skills

3) Ability to handle potentially sensitive, complex, and challenging group dynamics and, where required, able to have overt discussion about areas of potential disagreement.
4) Collaborative problem solving experience and knowledge of participative approaches.
5) Analytical skills and ability to manage qualitative data
6) Knoweldge of safeguarding adults and relative lawful compliance
7) Ability to promote an open, reflective learning culture [QM 4.3.1 & 4.3.2, QM 6.3.1]

2. Stage 2: Write to Chief Officers

2.1. Where it is agreed a SAR will be commissioned, a letter from the (SAR/SAB) Independent Chair is sent to the named chief officers of all agencies involved. The letter sets out the details of the SAR with Key Lines Of Enquiry and or terms of reference and a case summary. Each chief officer will nominate a person (at managerial level) within their organisation to represent their agency on the Safeguarding Adults Review Panel (Please note: Where possible, this person must not have had any direct involvement in the case).

2.2. Any requested report, or agreed alternative, should be sent to the Business Unit within the agreed timescales given in the letter.

3. Stage 3: Set up SAR Panel

3.1. Following the appointment of the Independent Reviewer, a multi-agency panel will be set up to manage the SAR at the earliest opportunity.

3.2. In most situations, the Independent Reviewer will chair the SAR panel.

3.3. The role of the SAR Panel is to agree the terms of reference, scrutinise information submitted to the review and support the Independent Reviewer. The panel should be proportionate to the nature and complexity of the review but must comprise a minimum of three members, one from each of the statutory members (Local Authority, Police, ICB) in addition to a chair. In most cases, representative will be identified from the SAR consideration panel to ensure consistency within the process and decision making.

3.4. Panel members should also be invited from other relevant agencies that have had involvement in the case or who can bring expert knowledge.

3.5. All panel members, where possible, must be independent from the case under review (i.e. did not have case responsibility or supervised the case worker directly) and with appropriate level of seniority [QM 6.3.2]

3.6. Panel members play a critical role in delivering the review and their roles and responsibilities are set out in Appendix 8. Every effort must be made by partner agencies to avoid a change in their panel representative after the first panel meeting has concluded [QM 5.1.4]

3.7. The initial panel meeting will address the key topics including but not limited to:

1) An overview of Safeguarding Adults Reviews
2) The role of the Panel, its members and including an expectation that people are cared for and relationships fostered throughout the process [QM 7.1.2]
3) Case synopsis
4) Scoping period of the Review / Key Lines of Enquiry including any additional KLoE required
5) Contact with family
6) Parallel processes (including Police investigations / Coroners Inquest)
7) Consideration of any similar SARs previously undertaken and their recommendations
8) Outline of methodology to be used
9) Consideration of practitioner engagement
10) Timetable for panel meetings and review milestones

3.8. Additional panel meetings as required will be agreed by the SAR panel and Independent Reviewer. Each version of the draft report will be marked separately for audit purposes.

3.9. The Business Unit will keep the SAR Subgroup updated on progress of the review at regular points during the process. The SAR Subgroup Chair will provide updates to the SAB on the progress of the review. [QM 7.4.2]

4. Stage 4: Contact with family – ongoing commitment [QM 11]

4.1. The Independent Reviewer with support from the Business Unit will write to the individual and/or family in cases where the subject is no longer alive to inform them of the SAR, to hear their views and explain the purpose and process of the SAR. The Independent Reviewer / Head of Service / Business Manager will keep the individual and/or family regularly informed of progress throughout the review. [QM 3.1.1]

4.2. In cases where the subject of the review is alive the Independent Reviewer / Head of Service / Business Manager will seek to gain their consent to share information and complete the SAR, as well as explaining the process and hearing their views. To ensure that the subject is fully supported in this an advocate should be available to assist if required. If the subject does not have access to a suitable person, the local authority Adult Social Care shoud arrange for an advocacy service to be available via the Local Authority contract.

4.3. In cases where the subject of the review is alive but does not have capacity, the Independent Reviewer / Head of Service will contact the Next of Kin / Relevant Person to explain the purpose of the review and inform them of progress throughout the review

4.4. Although it is best practice to obtain consent in such a situation it is not a statutory

requirement as outlined in s45 of the Care Act. Therefore, lack of consent or capacity should not impede the progress of the SAR.

4.5. The adult(s) and/or family should also be given the opportunity to discuss the SAR final draft report, its conclusions, recommendations, and their experiences of the process. This can be done via the Independent Reviewer [QM 3.1.1 & 3.1.2, 11.2.7-9] or Business Unit Head of Service, and the report will show clearly how those views have been incorporated into the analysis, where appropriate [QM 13.2.8].

5. Stage 5: Gathering of information [QM 9.1.1 – 9.2.5, 9.3, 9.4]

5.1. Depending on the methodology agreed, the SAR Panel may receive copies of information / reports / chronologies via the SAB Business Unit which will be evaluated by members at a panel meeting.

5.2. This information will be returned to the SAR panel member concerned if the information is considered

1) incomplete (including lack of chronology),
2) unclear,
3) Failing to consider critical information,
4) Lacking information to evidence decision making
5) Requires further clarification

5.3. Any clarification or amendments to agency information must be returned to the Business Unit within seven working days.

5.4. The Independent Reviewer may hold individual meetings / telephone discussions outside of panel meetings to ensure information is clearly presented and understood.

6. Stage 6: Options for discussion with practitioners involved [QM 10]

6.1. Depending on the methodology selected, practitioners involved in the case may be invited to workshops during the production of the report or following the final report to consider the learning from the case. The aim of the workshop is to support understanding about why practitioners made particular decisions and to understand the perspectives of other agencies.

7. Stage 7: Presentation of draft report

7.1. The Independent Reviewer will draft an overview report, drawing out relevant points and significant events, guided by the Key Lines of Enquiry as set out in the Terms of Reference. It will explore how organisations have worked together to comply with safeguarding procedures, identify lessons to be learnt, any policy/procedural challenges to be addressed and a conclusion to the SAR. This will be written with a view to publication (if appropriate) and in a suitably anonymised format.

7.2. The Independent Reviewer will present the draft report to the SAR Panel for

discussion and agreement, and for each organisation involved to check factual accuracy. [QM 13.1.6]. Any observations or suggested amendments to the draft report are to be supplied to the Independent Reviewer within 14 working days for consideration. If a panel member disagrees with the views of the Independent Reviewer and these cannot be resolved by consensus the dispute resolution process will be used [QM 6.2.3, 13.1.7] see Section 10 above.

8. Stage 8: Submission of final draft report

8.1. The final draft report is agreed and quality assured through the following process:

1) Partner agencies who are part of the SAR Panel agree the final draft report through chief officer sign-off. Amendments to the final draft report will be considered and made at the discretion of the Independent Reviewer.

2) The SAR Subgroup signs off the final draft report ensuring they are satisfied that the panel's analysis and conclusions have been fully and fairly represented. If the SAR Subgroup identify gaps or areas in the report which require further work this is passed back to the Independent Reviewer for their consideration and actions.

3) The final draft report will be checked to identify any risk of legal challenge. For example, not containing libellous content, conveying any civil or criminal liability, referencing law breaking or breach of professional standards which has not been already managed [QM 14.2.3, 14.4.1].

4) Once the final draft report is agreed, the Independent Reviewer will present the SAR to the Safeguarding Adults Board for final approval and sign off. The SAB will decide to whom the SAR report, in whole or in part (executive summary), should be made available, and the means by which this will be done. Any reports to be published should be fully anonymised, dependent on the person or family view although prior to publication a pseudonym may be chosen (by the person or family wherever possible) to humanise the report. [QM 14].

9. Stage 9: Action planning and identification of risks

9.1. Every review will be supported by a written report / action plan / summary of findings (executive summary) written by the Independent Reviewer. The report will include recommendations for the board to consider and adopt if agreed. These recommendations must be SMART (specific, measurable, achievable, result-orientated and time-bound).

9.2. A Composite Action Plan will be held by the Business Unit. The Action Plan will be regularly monitored via the SAR subgroup, to check and evidence the progress of work made against each action.

9.3. It is the responsibility of SAB Board members and other organisations to ensure learning and service change from any SAR is understood, supported, embedded, and evidenced within their organisation and across the partnership.

9.4. Agency actions identified by the SAR should genuinely support open and mutually challenging discussion about tackling the systemic risks identified by the review and

at the right levels of a system hierarchy [QM 15.1.1, 15.2.1].

9.5. Organisations will be held accountable for these actions at board meetings.

9.6. Any actions relating to areas of work within the remit of SAB subgroups will be passed to them. These actions are owned by the relevant subgroup chair who will be expected to submit regular updates to the Business Unit on progress made.

9.7. Recommendations arising from an individual agency Independent Management Review or from a Single Agency Learning Review, are the responsibility of that agency to oversee and implement any actions identified.

10. Stage 10: SAR publication and media strategy [QM 14.1-2-5]

10.1. Following formal sign-off of the SAR report by the SAB, there will be a period of four to six weeks to enable appropriate communication plans to be developed, agreed and shared with all relevant agencies [QM 14.2.5-8]. However, publication may be delayed due to ongoing proceedings or inquests.

10.2. A meeting will be held with SAB / SAR Subgroup representatives from the local authority, police, ICB and other relevant agencies as appropriate along with their communications leads to agree method of publication and engagement with the media (i.e. reactive or proactive media statements) [QM 14.1.6].

10.3. The impact of the publication on the person in the review, their family members [QM 11], practitioners, and others closely affected by the case, must be considered and their wishes taken in to account as part of the publication and media planning.

10.4. The arrangements of publication will be discussed with the family and appropriate steps taken to minimise the disruption and distress [QM 14.1.2].

10.5. The anonymised report will be published on the SAB Board website (in exceptional cases only the executive summary may be added, or it may not be published at all) and may also include any additional products, mediums and activities to support different audiences [QM 14.2.9-10]. The report will be shared with the SAR national repository where appropriate.

10.6. Between final sign-off by the SAB and the publication of the final report, it is the responsibility of SAR Panel / Subgroup members to inform any professionals from their own organisation who were directly involved in the case, of the contents of the report, schedule for publication and give appropriate support as needed [QM 14.2.6]

Appendix 1 –Referral Form

SAR Referral Form

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

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

A SAR is about promoting effective learning and improvement to prevent future deaths or serious harm occurring again. It relies on a spirit of openness to learning about what went well, as well as what could be improved.

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

REFERRER'S DETAILS			
Agency name:			
Your name:		**Your role:**	
Email address:			
Telephone:		**Referral date:**	

NB: If you have discussed this referral with your agency's Safeguarding Lead, please enter their details below:			
Name:		**Telephone:**	
Email address:			

PART A - Referral for a Safeguarding Adults Review

To be completed by the referring officer

Details of adult at risk of abuse or neglect			
Last name:			
Forename(s):			
Other names known as			
Date of birth:		**Date of death:**	
		Date of Incident:	
Gender:		**Ethnicity:**	
Religion:		**Disability:**	
Address:			
Housing provider			
GP surgery:		**NHS number:**	
Care and support need details:			

Details of family members and significant others			
Name	Address	Date of Birth	Relationship to subject of referral

Please state which of the following Care Act s44 criteria does this case meet?	
The adult has needs for care and support (whether or not the local authority has been meeting any of those needs) – *Please specify below:*	
There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or other persons with relevant functions **worked together** to safeguard the adult – *Please specify below, including in what way agencies did not work together which led to the abuse:*	

The adult has died and you know or suspect that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died) – *Please specify below to include what the abuse and/or neglect consisted of:*	
The adult is still alive and you know or suspect that the adult has experienced serious abuse or neglect – *Please specify below to include what the abuse and/or neglect consisted of:*	

Summary of what happened

Provide a brief summary of what happened – the events and circumstances that led to this referral; include when and where the event happened, and in what context.

Please do use plain language that can be understood by those with no prior knowledge of your agency; give the meaning of any acronyms you use.

Please do not copy and paste extensive information from your agency's records or case management systems.

Please identify the type(s) of abuse relating to this case (more than one may apply):

Click here for guidance on types and indicators of abuse

Abuse					
Domestic Abuse		**Physical Abuse**		**Discriminatory Abuse**	
Sexual Abuse		**Psychological Abuse**		**Organisational Abuse**	
Financial or Material Abuse		**Neglect: Long Standing**		**Neglect: Recent**	
Self-Neglect		**Drugs / Solvent**		**Alcohol**	
Hoarding		**Faith-Based**		**Homeless**	
Exploitation					
Countylines		**Trafficking**		**Sexual Exploitation**	
Modern Slavery		**Radicalisation**		**Forced Marriage**	
Online		**Cuckooing**			
Health / Medical Issues					
Injury		**Self-Harm**		**Suicide**	
Serious Illness		**Life-limiting illness (natural causes)**		**Lacks capacity**	
Mental Illness		**Learning Disabilities (unconfirmed)**		**Learning difficulties**	
Mental Illness (confirmed diagnosis)		**Learning Disabilities (confirmed diagnosis)**		**Deprivation of Liberty Safeguards (DoLS)**	
Other -					

Chronology of key events - Please use the chronology table below to outline any key events around the time of the incident. PLEASE NOTE: This should only include key significant events and DOES NOT need to be a detailed chronology at this stage.	
Date and Time	**Event**

OTHER PROCESSES & AGENCIES INVOLVED
Please provide details of any other processes you know to be underway in relation to this case, e.g. DHR, LeDeR, SI / RCA review, criminal investigation, coroner's inquest.
Please list any other agencies or services you know to be involved in this case. For example: social services, police, health services, fire and rescue, housing, probation services, ambulance, residential or domiciliary care, nursing homes.

Additional Information
Please add any additional information you think may be relevant and may assist decision making, including any possible learning arising from the case:

Appendix 2 – Initial Information

Referral Form PART B - Agency Information and Involvement

You have been identified as an agency who is known to have had, or may have had contact with the person who is the subject of this SAR Referral. In light of the focus and time period of the SAR detailed above, we need make sure we have all the basic facts about the extent and nature of agency involvement with the person and any family members. Given the tight turnaround, we also want to know your agency reflections at this stage about strengths and weaknesses in practice, and the causes of those.

We are initially asking agencies to:

- *Check your agency's records to see if you have had contact with the person, their family members or close associates listed.*
- *Provide a brief appraisal of practice.*
- *Keep your agency's submission in relation to this case separate from the case records/files.*

Please return this document to the Business Unit before [insert date/time].

YOUR DETAILS	
Agency name:	
Name and job title of person completing the chronology	
Email address:	
Date of submission	

Declaration of contact	
Has the agency named above had contact with the adult (or family / close associates) listed in section 1 of this form?	
If you have answered No, you do not need to complete further sections and should return the form to the Business Unit If you have answered Yes, please complete the remainder of this form on the next page	
Agency information for the time period under review (narrative summary)	
Please summarise in a paragraph or two, how your agency has been involved with the person(s) subject of this SAR during the time period under review. Give a brief description of the nature and frequency of your involvement.	
(Enter text here)	
Historical context of agency information (narrative summary)	
If your agency had involvement with the person **before the period under review**, please summarise it here.	

(Enter text here)
Summary of reflections on your agency'
Please provide **an overall view on what was good and where there were problems**, in the agency activity reviewed, highlighting any key issues.
(Enter text here)
Please identify **any areas for concern as to the way in which partners have worked together** to safeguard the subject/s. and contributory factors.
(Enter text here)
What are **the main wider systems issues that were at play** in this case? What are the underlying causes that need to be tackled to enable improved practice in the future?
(Enter text here)
Any other issues, factors or information to note?
(Enter text here)
Please include any further relevant information that you wish to bring to the attention of the SAR Subgroup meeting or issues you would like to see discussed at this meeting.
(Enter text here)

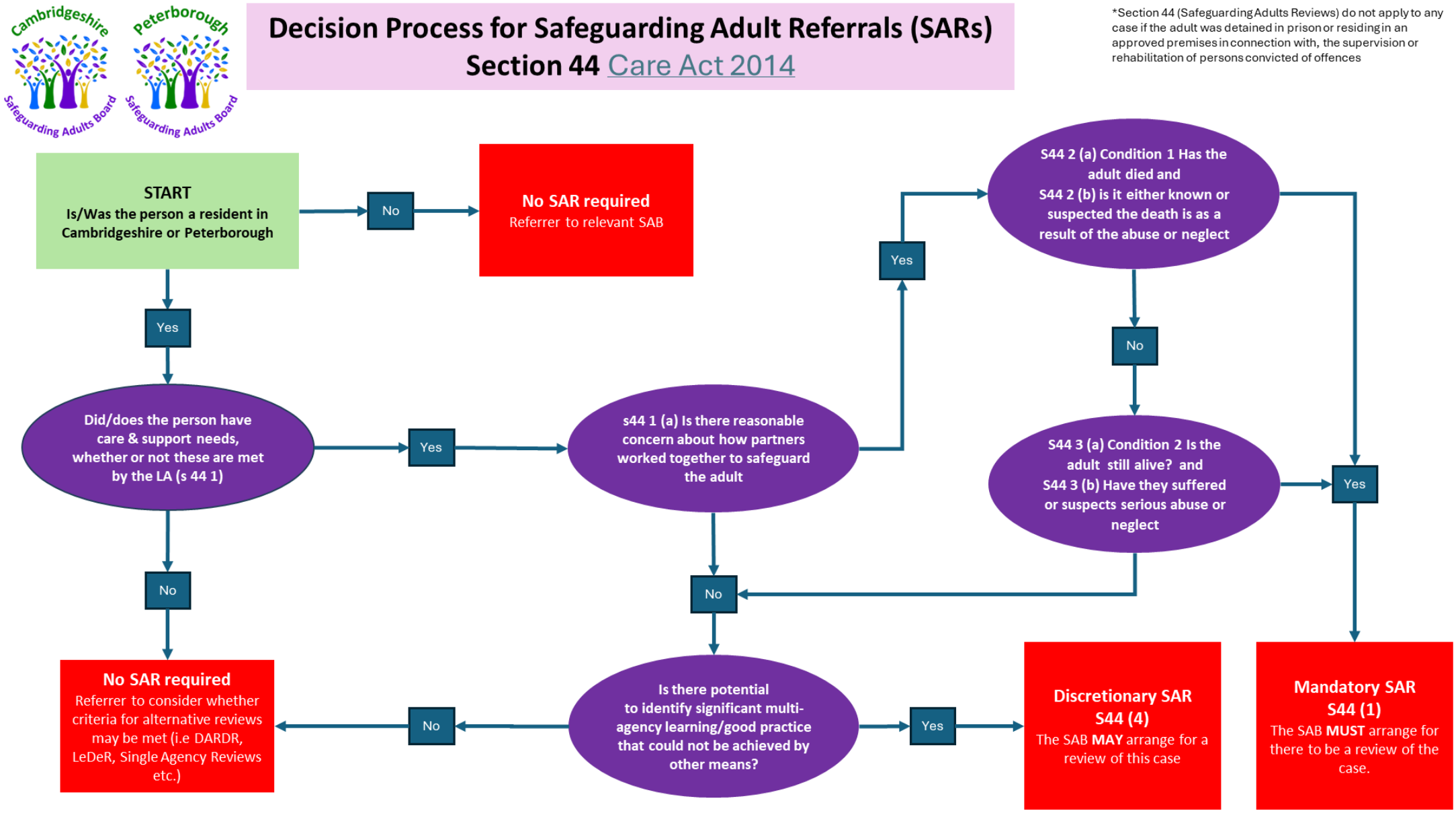
If you have identified any initial learning for your agency while completing this analysis, please complete the table below. This will help inform the decision of the Rapid Review panel and any subsequent LCSPR should this be necessary.

Learning identified	Action taken (including timescales)	Outcome / /impact

Thank you

Once completed please email the completed form to: safeguardingboards@cambridgeshire.gov.uk

Appendix 3 – SAR Decision Tree and Checklist



QUESTION	YES	NO	COMMENT
Did / Does the individual have needs for care and support?			
Was there a “near miss”? (serious harm or death averted)			
Does the case indicate that there may be failings in how our adult safeguarding multiagency policies and procedures function, leading to serious concerns about how professionals/ services work together?			
Did the system recognise/share evidence of risk of significant harm to an adult (or recognise/share it late)? Is there evidence that system conditions lead to poor multiagency working or communication?			
Does that case involve serious or systemic organisational abuse and multiple alleged perpetrators, from which learning could be transferred to other organisations to prevent such abuse or neglect in the future?			
Could the case potentially yield systems learning around how agencies work together to prevent and reduce abuse and neglect that would help us do things different in the future?			
Would a SAR enable the SAB to identify areas of practice to prevent serious abuse or neglect happening?			
Does intelligence from other quality assurance and feedback sources (e.g. audits/complaints) suggest that the kind of issue in this case is new/ complex/ repetitive and conducting a SAR would therefore be beneficial?			
Has this happened before in Cambridgeshire or Peterborough and was a SAR commissioned then? Has the learning from any previous SARs been implemented or is there new learning to be identified?			
Is there adverse media interest or serious public concern?			
Is there evidence of sufficient good practice that could be mainstreamed across the partnership to the benefit of adults and their families?			

Appendix 4 - Overview of Parallel Reviews

Effective local liaison is required between Multi-Agency Safeguarding Arrangements, Adult Safeguarding Partnership Boards, Community Safety Partnerships and Multi-Agency Public Protection Arrangements to determine the most appropriate review process to maximise learning and minimise duplication of effort and reduce anxiety for families involved.

Reviews Following the Death of an Adult or Child in England

The following summarises statutory and discretionary reviews that may be undertaken in England following the death of an adult or child. It includes the review name, legal basis, criteria for when the review should be undertaken, who it applies to, and its purpose.

Statutory Reviews

Review Name	Legal Basis	Criteria for Review	Applies To	Purpose
Child Death Review (CDR)	Children Act 2004	All deaths of children under 18, excluding stillbirths	Children under 18	Understand circumstances, identify modifiable factors, improve child health and safety
Domestic Abuse Related Death Reviews (DARDR) previoulsy known as Domestic Homicide Reviews (DHR)	Domestic Violence, Crime and Victims Act 2004	Death of a person aged 16+ due to violence, abuse or neglect by a person to whom they were related, with or was in an intimate personal relationship or a member of the same household	Adults (16+)	Learn lessons to prevent future domestic abuse-related deaths
Safeguarding Adult Review (SAR)	Care Act 2014	Death or serious harm of an adult with care and support needs due to abuse	Adults with needs for care and support	Identify lessons to improve safeguarding practice and inter-agency

		or neglect		working
Child Safeguarding Practice Review	Children Act 2004	Death or serious harm of a child due to abuse or neglect, or where learning can improve safeguarding	Children	Identify lessons to improve safeguarding practice and inter-agency working
Coroner's Inquest	Coroners and Justice Act 2009	Deaths that are violent, unnatural, sudden with unknown cause, or in state detention	All individuals	Determine cause of death and circumstances
Offensive Weapons Homicide Review* *Currently in pilot stage	Police, Crime, Sentencing and Courts Act 2022	Homicide involving offensive weapons where the victim is aged 18+	Adults (18+)	Prevent future serious violence and homicide

Discretionary or Policy-Driven Reviews

Review Name	Legal Basis	Criteria for Review	Applies To	Purpose
LeDeR (Learning Disabilities Mortality Review)	NHS England policy	Death of a person with a learning disability	Adults and children	Identify care improvements and reduce inequalities
Mental Health Homicide Review	NHS England policy	Homicide committed by someone known to mental health services	All individuals	Improve mental health care and risk management
Death of a Homeless Person Review	Local safeguarding guidance	Death of a person who was homeless or rough sleeping	Adults	Identify systemic failings and improve multi-agency

				responses
Drug and Alcohol-Related Death Review	Local authority/public health	Death due to substance misuse, especially if known to services	All individuals	Improve prevention and treatment strategies
Death in Custody Review	IOPC / PPO	Death in police, prison, or immigration detention	All individuals	Ensure accountability and improve custodial care
NHS Serious Incident Review / Independent Investigation	NHS England Serious Incident Framework	Death in NHS care where there are concerns about service delivery	All individuals	Ensure transparency, learning, and accountability

Appendix 5 - Guiding Principles and Purpose of Carrying out a SAR

The SAR must be timely

The SAR Panel should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it (locally agreed as the date of the first panel meeting), unless there are exceptional circumstances for a longer period being required.

Every effort should be made whilst the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

There is an expectation that, where criminal proceedings are ongoing, the work of the SAR will go ahead **only after consultation** with relevant police colleagues and/or Crown Prosecution Service (as below), and then in accordance with the usual timescales, unless there are special circumstances which would require some compromise.

If, exceptionally, it is the view of (i) the Senior Investigating Officer, where the case is at the investigative stage and (ii) the Senior Investigating Officer and a prosecutor of at least Deputy Chief Crown Prosecutor rank, where the case has been charged, that there would be irreparable prejudice to the criminal investigation if the SAR were to proceed while the criminal proceedings were still ongoing, they will communicate the reasons for their opinion to the SARG.

All contacts, decisions and actions will be recorded in a SAR log in order to enable an audit trail.

The SAR must be impartial

The review will be conducted fairly and impartially.

The SAR must be thorough

The review process is committed to exploring each of the Terms of Reference in detail.

The SAR must be open

The review and its outcomes should be shared appropriately with all partners involved in NSAB.

The SAR must be confidential

All information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so with the agreement of originating agencies or owners.

The Care Act 2014 provides a statutory basis for undertaking the learning and review processes. As such this policy will adopt the following principles as set out in the Care Act:

- This Policy recognises that there are other forms of statutory reviews (such as domestic homicide reviews, Multi-Agency Public Protection Arrangements (MAPPA) reviews, children's safeguarding practice reviews, etc.) and the importance of managing the interface between these.
- The SAR should be proportionate according to the scale, significance, and level of complexity of the issues and concerns highlighted.
- Adults and their families must always be offered the opportunity to contribute to the review

process and receive feedback on the learning outcomes achieved

- All agencies involved in the case should be fully engaged in the safeguarding adult review process and have the opportunity to contribute their views.
- The central focus of the SAR will be to gain insight and understanding of how effectively agencies were working together to support and safeguard the person at risk and to identify any actions needed to improve future practice and partnership working.
- The SAR process should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew or could have reasonably been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.
- A SAR is not a disciplinary process and should be conducted in a manner which facilitates learning and allows for reflection.
- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a SAR.

Appendix 6 - Selection of SAR Independent Overview Report Writer

To ensure best value, the aim should be to obtain at least three quotations for each appointment of an Independent Report Writer. It is recognised that the market for this work may be constrained at times so that less than three quotations may be obtained.

Quotations will be obtained through appropriate advertising, for example via the Independent Chair's Network.

A valid Quotation will consist of:

1. An expression of interest in carrying out the work.
2. A note of availability to start work.
3. The hourly / daily rates for carrying out the work together with a (non-binding) estimate of the total time and cost to be incurred. This may be expressed as a range.
4. The report writers CV, supplemented by a note of the relevant experience of the report writer to this particular review, and evidence of experience of undertaking reviews (published/unpublished)
5. Details of references that may be undertaken, where the report writer is not already known to the SAB.
6. The report writer has declared they hold no conflicts of interest in undertaking this commission.

The SAR subgroup members and Independent SAR Subgroup Chair will assess the Independent Reviewers using the following table. The group will rank each applicant in priority order.

Table A

0	Question not answered / failed to reference
1	Limited response to question, some criteria evident
2	Majority of the question answered, criteria demonstrated with some minor gaps, little concerns with the response
3	Question fully answered, significantly met or exceeded criteria, no concerns with the response

Using the above scoring matrix, please score the author's expression of interest / application

	KEY Criteria	Score	Evidence
1	Does the applicant have previous experience of or authored Serious Case Reviews (SCRs) / SARs?		
2	Does the applicant have experience of working at a senior level within health, adult social care, police or community safety?		

3	Does the applicant have appropriate background experience relative to the subject matter		
4	Does the applicant have knowledge and application of alternative methodologies		
5	Does the applicant have experience of charing and present to multi-agency meetings, including facilitating information gathering events / practitioner learning events?		
	Does the applicant have knowledge of relevant legislation and themes outlined in the review?		
8	Does the applicant have a connection with local agencies / organisations or a conflict of interest?		
9	Any additional comments to include:		
10	Should this reviewer be considered to undertake the SAR?	Y / N	

Appendix 7 – Methodology Options

The process for undertaking Case Reviews should be determined locally according to the specific circumstances of individual cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however, it will be determined by, and be proportionate to, the specific circumstances and the scale of the situation.

Examples of different types of methodologies include:

Traditional Review Model

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice. This model includes

- The appointment of review group, or panel, including a Chair (who must be independent of the case) and core members who determine the terms of reference and oversee the process.
- Appointment of an Independent Report Author to write the overview report and summary report.
- Involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning.
- Chronologies of events.
- Formal reporting and monitoring across partnership.

The benefits of this model are:

- It is likely to be familiar to partners.
- There is possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- It provides a robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- It is resource intensive.
- It is costly.
- It can sometimes be perceived as punitive.

It does not always facilitate frontline practitioner input.

Appreciative Inquiry

Case reviews conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong and/or did not have the desired outcome.

They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements.

To undertake a case review using the Appreciative Inquiry principles, the facilitator should be familiar with AI and confident in putting this into practice. Appreciative Inquiry is facilitated through the use of strengthen based, solution focused language.

Appreciative Inquiry can be used within any methodology of case review.

Benefits of this model are:

- Keeps the child at the centre
- Promotes reflective discussion and enhances critical thinking and analysis
- Enhances the use of structure professional judgement
- It is all about relationships- making a difference through a strength based approach
- Encourages professional curiosity
- Embraces and facilitates a learning culture
- Aims to progress timely and meaningful outcomes for children and families

Drawbacks of this model are:

- Potential to ignores or even deny problems
- May lead to over optimistic outcomes
- Potential to not intuitively dig deep enough

Reflective Learning Session or Multi- Agency Practitioner Events

Where an independent review is not required, information is gathered from agencies to contribute to a reflective learning session, attended by the relevant professionals to critically appraise the case and learning recommendations agreed.

Benefits of this model are:

- Wide range of professionals involved, including those involved in the case and those not involved in the case.
- Proportionate and timely
- Allows the referrer to be actively involved in discussion

Drawbacks of this model are:

- Relies on having a robust amount of information prior to, or during discussion to enable the right conclusions to be drawn.
- Requires a strong facilitator

Individual Agency Review

This model would be relevant when a serious incident identifies single agency involvement or where potential one agency learning has been identified.

There are no implications or concerns regarding involvement of other agencies and it is appropriate that lessons are learnt regarding the conduct of an agency.

Such reviews could be requested by the Safeguarding Partnership. If undertaken individually by an agency, the agency concerned should inform the Partnership they are undertaking an Individual Agency Review with a safeguarding element, in order for the Partnership to consider any transferable learning across the partnership.

The benefits of this model are:

- Provides an opportunity for learning from an individual agency.
- Enables individual agency scrutiny into a specific area.
- Assists a 'Duty of Candour'.
- Supports the sharing of learning to further strengthen a whole system approach to safeguarding

The drawbacks of this model are:

- Can be seen as outside the purpose of multi-agency learning.
- Requires individual agency full buy in and ownership. Risks individual agency opposition.

Multi-Agency Audits

Multi-agency audits of case files that relate to a specific theme is an effective mechanism of understanding practice at child level and practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made.

A rolling programme of multi-agency audits themes is identified through local priorities, local reviews, inspection findings, performance data and national research.

Benefits of this model are:

- Proportionate
- Can utilise multi agency auditors
- General thematic learning which can
- be consider system wide

Drawbacks of this model are:

- Conclusions from the view point of one or two auditors rather than wholly multi-agency.

Peer Review Approach

A peer review approach encompasses a review by one or more people who know the area of business and accords with self-regulation and sector led improvement programme.

Peer review methods are used to maintain standards of quality, improve performance and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- Peers can be identified from within the Safeguarding Partnership.
- Or peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- Increased learning and ownership if peers are from within the Safeguarding Partnership.
- Objective, independent perspective.
- Can be part of reciprocal arrangements across/between partnerships.

The drawbacks of this model are:

- Capacity issues within partner agencies may restrict availability and responsiveness.
- Skills and experience issues if reviews are infrequent.

- Cost effective.

Potential to perceive peer reviews from members of the partnership as not sufficiently independent, especially when they concern political or high-profile cases.

Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If the contributory factors and causal factors - the root causes - of an incident or outcome are understood, corrective measures can be put in place.

By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. This approach can help to prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes.
- To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence.
- There is usually more than one potential root cause of a problem.

To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause(s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS.
- Focus is on the root cause and not on apportioning blame or fault.
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

Appendix 8 - SAR: Guidance for Panel Members

Introduction

The overall purpose of a Safeguarding Adults Review (SAR) is to promote learning and improve practice, not to re-investigate or to apportion blame.

The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

Lessons learnt are shared to maximise the opportunity to better safeguard adults with care and support needs, who are or may be at risk of abuse or neglect. The Care Act 2014 requires that lessons learnt are published in the Safeguarding Adults Board's annual report following the conclusion of the review.

It is vitally important that all panel members contribute to the work of the review in such a way that reinforces a focus on learning and not about apportioning blame.

The role of the panel

While each SAR can adopt different methodologies, they will all include a SAR Panel (SARP).

The Business Unit will identify and convene an appropriate SARP. The SARP will comprise relevant representatives (appropriately placed to assist the review) from the key agencies involved in the case.

The SARP will be chaired by either a senior manager from an agency not involved in the case or the IRW.

The role of a panel member

All SAR panel members agree to work to the aims and underpinning principles as set out in the SAR Guidance

As a panel member you have a vital role in supporting the review as it completes its work and delivers a report. While each panel member will represent their own agency, they also share a collective responsibility to support the independent reviewer to scrutinise the information provided by agencies. Panel members will also provide local context and challenge to the analysis of professional practice and the identification of learning. Where an agency report is not of the quality expected, the reviewer will make contact with the relevant agency via the panel representative and ask for the report to be revised and resubmitted in a timely manner.

In support of delivering the review all panel members will:

- ensure the terms of reference for the CSPR clearly identifies the key lines of enquiry for the review, based on the learning from the Rapid Review, and National Panel's feedback
- work in collaboration with the Business Unit to identify a reviewer who is independent of the case

- Identify gaps in panel membership and agency information
- Ensure all required, requested and appropriate information is provided to the reviewer
- support the reviewer to contact family members (as appropriate)
- identify appropriate practitioners to be involved in any information gathering event / workshop
- be a conduit back to their organisation for any specific requests from the reviewer or review process.
- provide feedback to the reviewer when a draft report is produced, to ensure accuracy of the content.
- Agree the recommendations arising from the review

In addition to the above, Panel members will be required to

- Actively participate in the panel's discussions sharing all relevant information. This enables the panel as a whole and the reviewer to develop a comprehensive set of information to identify learning
- Ensure that agency recommendations are specific, measurable, achievable, relevant and time-bound (SMART)
- Act as a 'critical friend' to other panel members and help encourage reflection of the issues being discussed.
- Value the learning from different inputs and stay open to new ways of doing things.
- Be present in the meeting, and don't attend to non-meeting business. Listen attentively to others and don't interrupt or have side conversations.
- Communicate with their chief officer/s and / or senior management team on progress of the review, in order to cultivate ownership of the conclusions, and avoid any surprises about the learning being identified
- Supporting members of staff from their organisation attending review events (i.e. information gathering events). This includes providing suitable support and briefing before, during and after the event.
- Provide feedback to staff at all levels within their organisation on the progress and findings from the review

During panel meetings panel members are encouraged to:

- **Use specific examples** and agree on what important words mean. This ensures that all panel members are using the same words to mean the same thing.
- **Explain reasoning and intent.** This enables panel members to understand how others reached their conclusions and see where reasoning differs.
- **Focus on interests, not positions**. By moving from arguing about solutions to identifying needs that must be met in order to solve a problem, we can reduce unproductive conflict and increase our collective ability to develop solutions that can be helpful to the widest possible audience.
- **Test assumptions and inferences**. This ensures that the panel is making decisions with valid information rather than with members' private stories about what other panel members believe and what their motives are.
- **Jointly design next steps**. This ensures that everyone is committed to moving forward together as a review.

- **Discuss undiscussable issues**. This ensures that the panel addresses the important but undiscussed issues that are hindering its results.

Appendix 9 - Media strategy for response to serious incidents led by Safeguarding Board

In the event of a serious incident or publication of a Child Safeguarding Practice Review or Safeguarding Adults Review; the Safeguarding Partnership Board will have a single initial point of contact for the media which will be the Communications Team at the Local Authority.

Members of the Board should only talk to the media after having first cleared this with the local authority's Communications Team.

Anyone speaking on behalf of the Safeguarding Partnership Board must ensure that the media knows who they are representing.

Public and media interest

It is the responsibility of designated senior managers in each agency, alongside the Chair of the Safeguarding Partnership Board, to anticipate public and media interest in the death or serious injury of a child or adult at risk, or in the investigation of organised abuse under the umbrella of the Safeguarding Partnership's safeguarding procedures.

The chair, together with the designated senior managers in liaison with their press offices, must consult to formulate and agree a strategy for managing public information and make the necessary and timely arrangements for any media activity. When agreeing a strategy for managing public information consideration must be given to the following:

- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others;
- The accountability of public services and the importance of maintaining public confidence in the process of internal review;
- The need to secure full and open participation from the different agencies and professionals involved;
- The responsibility to provide relevant information to those with a legitimate interest;
- The constraints on sharing information when criminal proceedings are outstanding, in that access to the contents of information may not be within the control of Safeguarding Partnership Board.
- It is the duty of senior managers to ensure that all staff undertaking enquiries are aware of the agreed strategy and response to approaches by the public and media representatives, and are enabled to proceed with their work without excessive public pressure and exposure.

Specific media enquiries

A dialogue with key contacts will be established to determine which organisation will take lead responsibility for responding to media enquiries relating to any specific event. This initial dialogue will establish which matters, if any, will be handled collectively by the safeguarding partners and which will be handled by individual board partners. A decision will also be made whether to publish a proactive statement or reactive statement on behalf of the safeguarding partnership.

Ongoing responsibility for co-ordinating this activity will remain with the local authority Communications Team, except where the key contacts agree that the press office of another board partner will take the lead in a particular case. The Head of Service for the Cambridgeshire and Safeguarding Partnership Board will be kept informed of all actions undertaken and will be sent a copy of all communication with the media for inclusion in the audit trail.