Suffolk County Council

Suffolk
Safeguarding Adult Board

Safeguarding Adult Review Protocol

2015/17

Revised August 2015 by Paula Youell, Head of Adult
Suffolk Safeguarding Service

Contents

Safeguarding Adult Review Protocol

1. Introduction

The purpose of this document is:

- To ensure that local practice is in line with the Care Act 2014
- To support the view that the public interest is best served by the presence of an effective Safeguarding Adult Review process
- To facilitate a consistent approach to the process and practice in undertaking a Safeguarding Adult Review
- To acknowledge the statutory requirement for agencies to cooperate with such reviews.

2. Statutory Requirements of the Care Act 2014

2.1 The Care Act 2014 and the accompanying statutory guidance (14.133-14.149) sets out the requirement on Safeguarding Adults Boards to conduct Safeguarding Adults Reviews.

2.2 Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. (s14.133)

2.3 SABs must also arrange a SAR if an adult in its area has not died, but 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. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. (s14.134.)

2.4 The SAB may arrange for a SAR in any other situations involving an adult in its area with needs for care and support where it believes there is value in doing so. Cases for a SAR not involving death or serious abuse or neglect may be selected because they allow the SAB to proactively address issues of concern for example:

- A case will provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
- Examples of good practice can be explored where lessons can be identified and applied to future cases

2.5 Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them. (14.136)

2.5 The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

2.6 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

2.7 The purpose of the SAR is not to hold any individual or organisation to account 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

2.8 It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial

Where there are possible grounds for a Safeguarding Adult Review, a Domestic Violence Homicide Review, Safeguarding Children Safeguarding Adult Review, Multi Agency Public Protection Review, Mental Health Service Review or other such formal review process then a decision should be made at the outset by the decision-makers involved as to which process is to lead and who is to chair with a final joint report being taken to the necessary commissioning bodies.

3. Criteria for conducting a Safeguarding Adult Review

3.1 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 Act statutory guidance 14.141)

3.2 The SAB **must** arrange a SAR if an adult in its area has not died, but there is knowledge of suspicion that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

3.3. In cases where the SARAP receives a referral for consideration of a SAR and the decision is not to instigate the SAR process, the rationale for this decision will be communicated to the referrer. The SARAP will offer further advice on how the matter may best be examined outside of the SAR process. All decisions made will be held on record.

4. *Initiating a Safeguarding Adult Review*

Referral

- Any agency, or professional may refer a case believed to conform to the criteria and guidance (as outlined in paragraphs 2.2, 2.3 and 2.4 above) using the format set out in Appendix A. Referral should be made to the Safeguarding Adult Board Manager, together with a brief outline of the case and the factors that suggest that it is appropriate for Safeguarding Adult Review. Team managers or others chairing adult safeguarding case conferences will be particularly well placed to identify those cases that warrant review.

SARAP

- A summary of a case which potentially meets the criteria will be presented to Independent Chair of the SAB, who may then initiate the SAR process by contacting members of the SAB to convene the Safeguarding Adult Review Panel

Decision

- The SAR referral will be considered by the SARAP group and a decision will be made on whether or not the referral will be accepted. In considering the referral the referrer may be asked by the SAR group to provide additional information via a conversation with the SAB Manager

Panel

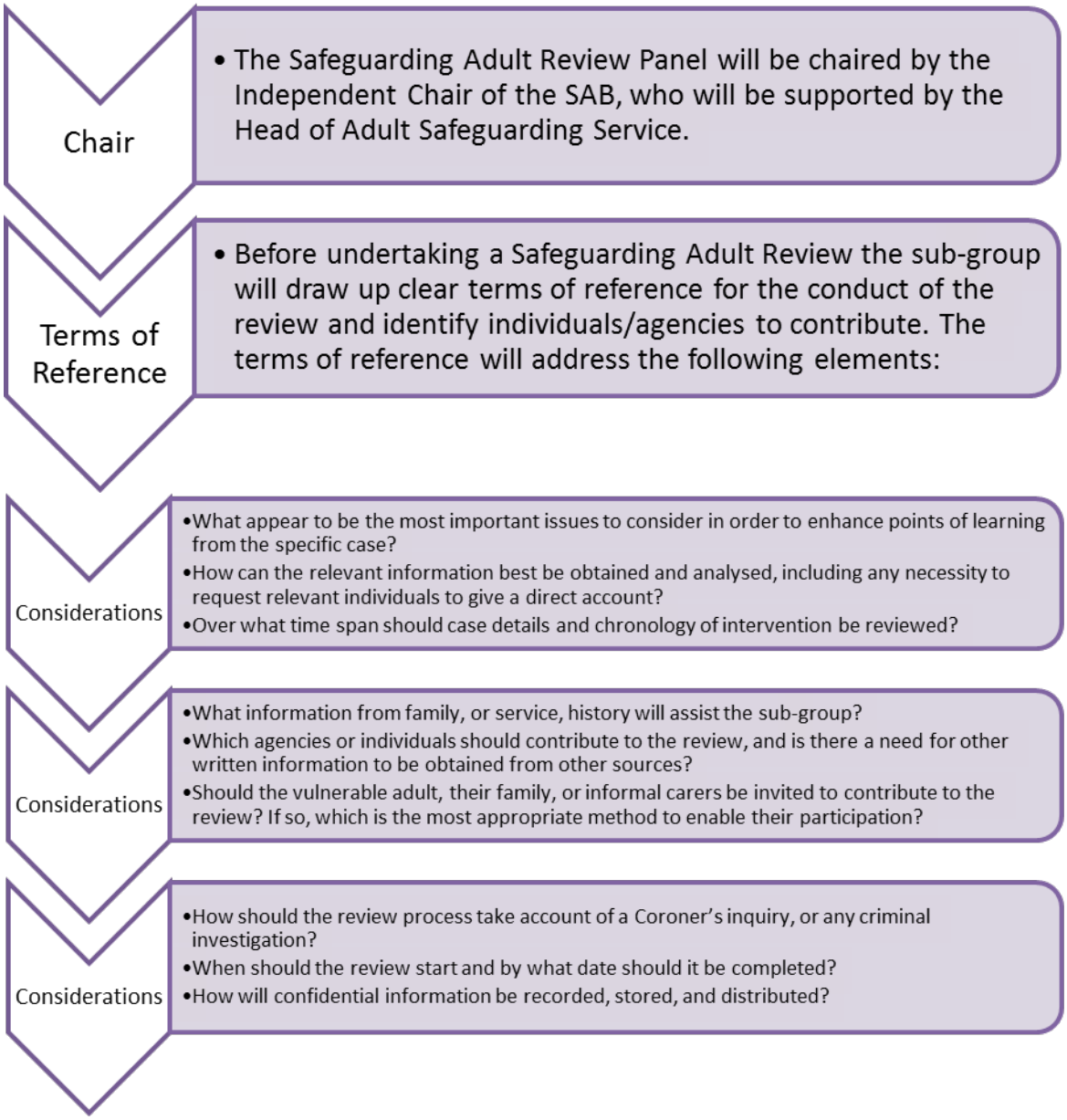
- Any case that is considered appropriate for a Safeguarding Adult Review will be delegated by the Chair of the SAB to a Safeguarding Adult Review Panel. This will comprise of at least one, or more, delegate from the following areas

Members

- Suffolk Adult Community Services, Suffolk Police, Legal Representative from Suffolk County Council, Health Representative, This will form the core membership of the sub-group
- In addition to this core group additional members may be co-opted to address particular case issues

Experience

- Nominees will have appropriate levels of experience of adult safeguarding. In order to enhance the independence and objectivity of the sub-group, nominees selected to contribute to specific reviews will normally be chosen from an operational area that has no direct involvement with the case in question. The selection of contributors will be the responsibility of the Safeguarding Adult Review Panel Chair.



5. Conducting a Safeguarding Adult Review

5.1 Upon confirmation from the SAB that a case is to be reviewed, the SARAP will identify an independent author to conduct the review.

5.2 Whilst working with the report author, the Safeguarding Adult Review Panel will identify relevant contributory individuals and agencies.

5.3 The chair of the SARAP and Independent Author will agree the most appropriate SAR learning method which will then be cited in the methodology.

5.4 The Independent Author or the SAB Chair may chair the Panel meetings with participating organisations. The frequency of meetings will be dependent on the agreed learning method (methodology) and scope of the SAR.

5.5 The Panel will complete a review of the information commissioned, and will provide frequent updates to the SAB

6. Making Safeguarding Personal

6.1 Involving the person, their family and or carers within the Safeguarding Adult Review

From the outset consideration should be given to the breadth and depth of involvement of the person their family and or carers throughout the review process which should adhere to the following principles:

- Negotiation (that includes family input in determining the terms of reference for the review);
- Transparency in limits and opportunities (agreement is needed about the level and reach of participation);
- Inclusivity;
- Sensitivity (boards and review leads need to exercise considerable professional judgment in the methods and approaches adopted to facilitate participation);
- Evaluation (seeking feedback from family members on the process of any review will enable learning to be developed about family involvement).
- Disputes and complaints will be managed by the Independent Chair of the SAB

6.2 Role of Advocacy and support to the Person or Family

On instigation of the SAR process, the SARAP will identify an appropriate professional to make contact with the person and/or family. The purpose of the initial meeting will be to ask the person and/or family their preferred method of support throughout the process. Should the person and/or family choose to receive support, suggestion and considerations with the primary aim being to facilitate the person and/or families involvement within the SAR by establishing and maintaining a sensitive supportive and appropriate relationship which links the family with the Safeguarding Adults Review Panel.

Instances where the person and/or family member my lack capacity under the terms of the Mental Capacity Act 2005, and particular decisions are being sought or information is being given' all efforts will be made to provide that information, including the use of a specialist advisor if required.

In some cases, cultural and language barriers may exist and communication may require the services of a suitably qualified interpreter. If such a need arises, great care will be taken to ensure that all information is clearly relayed and understanding sought.

The role of the supporter in assisting the person and or family or carer in a SAR may involve:

- Using the advocacy cycle to identify the stages the supporter is working through with the person.
- Ensure there is a clear advocacy plan at the beginning of the advocacy relationship focused on what the person wants to achieve and that the plan is continually reviewed
- Ensure that the supporter and the person are clear on individuals needs throughout the process and review this continually to decide when best to end the advocacy relationship
- Explain the process of Safeguarding Adults Review, explain who the key people involved in a SAR are and what is considered their role, where required
- Explain the policy and guidance surrounding a SAR so that the person is clear what their rights are and what they can expect as best practice, where required
- Provide support where required to go through reports, write a statement and prepare/attend/debrief following meetings
- Advocate the effects of bereavement and loss whilst having regard to cultural or religious beliefs.
- Facilitate the introduction of suitable support agencies
- Support the management of any media attention upon a family
- Explain the role of a Coroner's officer within the investigation
- Formulate a strategy to enable them to exit from their role at the appropriate time

The supporter would not:

- Attend meetings where the person or family have or would not have been ordinarily invited
- Discuss information with others without the person's and or family's permission
- Receive written or verbal information which the person or family would not ordinarily receive.

6.3 Considerations on involving the person family and or carer

Stage of SAR	Question to Consider
Agreeing the Terms of Reference, what evidence is needed and what timescales are appropriate	How has the views of the person or family been taken into consideration when agreeing this?
Receipt of Evidence Meeting in order to query and comment on the chronology	How has the person / family had the opportunity to contribute to the chronology?
Report Writing	Where appropriate, have the person and/or family had an opportunity to provide a statement of what they consider occurred?
Discussion of evidence - Review the reports	How have the person / family been able to contribute to the discussion of the evidence? Have they been able to review the reports?
Translate recommendations into an action plan	How have the person / family supported the development of recommendations? How have they supported the Board to develop an Action Plan?
In General	Has their involvement been maximized where possible? How has feedback from the person / family been sought about how involved they feel in order to maximize the opportunity for them to support the process?

7. Disclosure of Information and documents to interested parties external to the SAR

7.1 The SAR process is conducted in accordance with the Safeguarding Adult Review Protocol. It is established in guidance and case law that in order for there to be openness and candour within the SAR process to enable the purposes of the process to be achieved, it is necessary to protect confidentiality particularly in relation to related agency reports. This must be balanced with general principles of openness and transparency applicable to public process, and compliance with relevant legislation in relation to disclosure of information.

7.2 Decisions regarding disclosure of information to the family or other interested third parties may vary according to the timing of any requests and the stage reached within the SAR process.

7.3 Any agency producing documents for the SAR will be required to makes its own decision regarding disclosure to third parties who seek this.

7.4 The SARAP is required to consider the appropriate means of participation of, and contribution by, the family (para 6.1 Protocol).

7.5 Other than the final report, documentation will not be disclosed to the family or other individuals external to the SAR process prior to the completion of the Report. This approach is consistent with the principles established by the High Court in Worcestershire Safeguarding Children's Board v HM Coroner [2013] and also the decisions of the Information Commissioner in claims against the London Borough of Haringey [Decision Notice FS50234513] and Plymouth City Council [Decision Notice FS50084360].

7.6 The Final Report will be subject to redaction as required by the Data Protection Act 1998 and will be provided to the family and other external bodies as deemed appropriate following full consideration of all issues.

7.7 Any request for access to documents will be considered in accordance with the principles of the Freedom of Information Act 2000 and the Data Protection Act 1998. Decisions will be made by individual agencies in relation to requests for disclosure of their documents, including the reports for which they are authors.

7.8 Any request for information by the family or indeed any other external parties to the SAR, addressed to individual organisations participating with the SAR process, should be processed in accordance with the applicable legal framework, primarily the Freedom of Information Act 2000, Data Protection Act 1998 and the Human Rights Act 1998.

7.9 A range of exemptions under the legislation referred to above could potentially apply to the information requested. The fact that there may be grounds for withholding disclosure does not automatically mean that this will follow. Decisions about disclosure should be made with reference to the circumstances that apply at that time and may change over time as the SAR progresses and is ultimately concluded.

8 Conduct of Safeguarding Adult Review:

8.1 Following the agreement on the methodology of the SAR, the initial meeting will convene which will agree:

- Who will chair the SAR panel
- The terms of reference
- The "evidence" required from each participant
- support and other resources needed (any perceived deficits to be referred to Chair of Safeguarding Adults Board)

- Time scales within which the review process should be completed
- Dates, times and venues of meetings
- The nature and extent of legal advice required, in particular, data Protection and Freedom of Information and Human Rights Act
- Involvement of the person/families and carers.
- The need for the completion and implementation of media and communication strategies.

9 Safeguarding Adult Review – Receipt of evidence

9.1 This stage of the process is a formal "information sharing" session where agencies will be encouraged to query and comment on the reports presented. Each agency involved will be asked to:

- Present and examine the chronology of events, highlighting any discrepancies

- Present a comprehensive report of the actions by their agencies
- Ensure any other management reports and other relevant information are made available

10. Links with other processes

10.1 In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a Domestic Homicide Review (DHR), criminal investigation or an inquest. Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for the organisations involved.

10.2 It will also be helpful if running a SAR and DHR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff.

10.3 Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the SAB manager to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

11. Issues Arising

If at any stage whilst undertaking the procedure, information is received which requires notification to a statutory body, e.g. Health and Care Professions

Council (HCPC), DfeS, regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

The Chair of the Safeguarding Adult Review Panel should report back to the Safeguarding Adults Board and a decision made as to whether the Safeguarding Adult Review process should be suspended pending the outcome of such notification.

12. Safeguarding Adult Review Methodology

12.1 No single model is prescribed for SARs. The choice of approach for each SAR is significant as how a review is conducted will influence the learning and whether the process is constructive and educative for those involved (SCIE 2015).

12.2 Examples (not exhaustive) of learning models which may be considered are:

• The SCIE learning together model

The Learning Together approach has been used in both safeguarding adults and safeguarding children's reviews. The model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture. Practitioners are part of the case review team, their perspectives are used to inform all aspects of the Review, including lessons learned.

• SILP (Significant Incident Learning Process)

This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

- Root Cause Analysis (RCA)

RCA has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

- Appreciative Inquiry (AI)

This approach is rooted in action research and organisational development, and is a strengths-based, collaborative approach for creating learning change. SARs 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; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements.

13. Implementing the review recommendations

13.1 On completion, the report author will ensure that contributing agencies are satisfied

14. Completion of an SAR

14.1 Independent SAR report author presents report to SAB who will endorse, subject to any amendments and agree key areas of learning.

14.2 SAR Group will meet to finalise recommendations and multi and / or single agency learning.

14.3 Recommendations and agency response will be monitored through the SARAP and reported into the SAB

14.4 SARAP to provide the learning to commissioned training provider for them to incorporate within their training.

14.5 SAB Manager to liaise with the Coroner in terms of an inquest date and publication of the SAR

15. SAR report publication decisions

15.1 The SAB chair should consider the following

- Public interest in seeing the report and understanding the issues raised by the case;
- The importance of ensuring that lessons are learnt and shared widely to improve services to adults;
- How these public interests can be balanced with those of any children and adults involved in the case;
- Whether the style and content of the report make it fit for publication;
- Whether there are any legal restrictions on releasing certain information in the report;
- What expert advice is needed e.g. from lawyers or medical or communications professionals; and how best to manage media interest in the case.

15.2 Translate recommendations from the summary report into an action plan, which will be endorsed by each agency.

The action plan will outline:

- Who will be responsible for various actions.
- The time-scales and targets for the completion of agreed actions.
- The intended outcome and purpose of recommended actions.
- The model used for evaluating, monitoring, and reviewing the necessary improvements in practice, policy, and/or systems.
- Clarify to whom the report, or sections of the report, should be made available.
- Disseminate the report, or key findings to interested parties and provide feedback and debriefing to staff, vulnerable adult, family, informal carers and media.

15.3 The Safeguarding Adults Board will ensure that all planned action are put into effect and will request updates from agencies

The action plan will remain on the Safeguarding Adults Board Agenda until such time that all recommendations have been implemented.

16. Annual Report

All Safeguarding Adult Reviews conducted within the year should be referenced within the annual report along with relevant service improvements

17. Individual agency responsibilities

Where an agency has been directly involved in a SAR they may have developed specific actions which will have been incorporated within the SAR report. All partners within the SAB should, as a minimum respond to a SAR as follows:

- On receipt of notification of the publication ensure that measures are taken to disseminate the report within the organisation.
- Agency managers should reflect on the content of the report and extract learning that is specific to their organisation or that has implications for their service(s). Actions or changes required to service provision should be identified and a clear action plan for these to take effect developed and report to the SAB.

- Team/staff meetings and individual supervision should include as an agenda item learning from the SAR based upon the individual agency needs and the briefing provided by the SAB.

18. Practitioners responsibilities

Anyone who works with Adults at Risk of abuse should actively engage with the learning opportunities provided by SARs. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- Reading SAB SAR publications
- Reading SAB SAR briefing notes
- Attending appropriate single and inter-agency training
- Contribute to staff and team meetings and supervision
- Support colleagues and staff in other agencies in implementing the learning from SARs

20. Role of Safeguarding Adult Board Manager

The Safeguarding Adult Board Manager will:

- Be a point of contact for the family
- Be a point of contact for person/agencies requesting a Safeguarding Adult Review
- Be a point of contact for individuals / agencies involved in other types of reviews who need to link to the Safeguarding Adult Board
- Be part of the Safeguarding Adult Review Panel in an advisory capacity
- Support the Safeguarding Adult Review Panel chair and play a major role in the SAR as directed by the chair
- Ensure that lessons learnt are disseminated through the Safeguarding Adults partnership to practitioners / managers / staff as appropriate
- Ensure reference is made in the Annual Report to any Safeguarding Adult Reviews undertaken

Appendix 1.

Request for a Vulnerable Adult Safeguarding Adult Review

Suffolk County Council Safeguarding Adult Review Protocol

REFERRAL & PROFESSIONAL DETAILS
(PLEASE FILL IN AS MANY CONTACT DETAILS AS POSSIBLE, ADD ROWS IF NECESSARY)

Please send this form once completed to the SARAP –
SABChair@suffolk.gcsx.gov.uk

Person requesting Safeguarding Adult Review:
Job Title:
Organisation:
Workplace:
Address:
Contact No:
E mail:
Other named contact:
Job Title:
Contact No:
Date and Time Referral Made

Brief Details of incident. Please include how you feel the incident meets the criteria for a Safeguarding Adult Review (see over page) **Date: Details:**

Brief Details of incident (please include location/address where alleged incident occurred)

Agencies known to be involved in case (including service provider): (include contact name and details if possible)

Any other information you feel is relevant:

Signed:
Print Name:
Date:

Appendix 2.

Care Act 2014 Statutory Guidance
Briefing Note: Safeguarding Adult Reviews (section 44)

The following briefing note describes the duty of the Safeguarding Adult Board to undertake a safeguarding adult review in specific circumstances. Each paragraph is cross referenced with the relevant chapter and paragraph number in the Care Act Statutory Guidance.

Safeguarding Adult Reviews

14.133 SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

14.134 SABs must also arrange a SAR if an adult in its area has not died, but 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. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

14.135 The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

14.136 Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

14.137. SARs should reflect the six safeguarding principles. SABs should agree Terms of Reference for any SAR they arrange and these should be published and openly available. When undertaking SARs the records should either be anonymised through redaction or consent should be sought.

14.138. The following principles should be applied by SABs and their partner

organisations to all reviews:
• There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
• The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
• Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
• Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and
• Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

14.139. SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

14.140. It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

14.141. 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. The recommendations and action plans from a SAR need to be followed through by the SAB.

14.142. The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult and, or, their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.

14.143. It is expected that those undertaking a SAR will have appropriate skills and experience which should include:
• Strong leadership and ability to motivate others;
• Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;

• Collaborative problem solving experience and knowledge of participative approaches;
• Good analytic skills and ability to manage qualitative data;
• Safeguarding knowledge;
• Inclined towards promoting an open, reflective learning culture.

14.144 The SAB should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.

Links with other reviews

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

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

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

Findings from SARs

14.148. The SAB should include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where the SAB decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation the SAB receives from registered providers which is relevant to CQC’s regulatory functions will be given to the CQC on CQC’s request.

14.149. SAR reports should:

• Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
• Be written in plain English; and
• Contain findings of practical value to organisations and professionals.

Reference the following:

☐ Learning from Review Framework

☐ Safeguarding Adult Review Policy

☐ Learning from Experience Database (forming part of the HSAB Website