



## **Safeguarding Adult Review Protocol February 2023 to January 2025**



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# 1. Acknowledgement

- 1.1 This policy is developed with acknowledgement to and using a wide variety of guidance and learning from Safeguarding Adult Reviews (SARs). Particular recognition is given to the Social Care Institute for Excellence (SCIE) and the available resources and to the Local Government Association (LGA) and Association of Directors for Adult Social Services (ADASS) *Making Safeguarding Personal* guidance to inform this policy for the involvement of people in SARs where appropriate.
- 1.2 This policy is developed in consultation with collective agreement under the Durham Safeguarding Adults Partnership (DSAP) governance arrangements.
- 1.3 The DSAP agree to adoption of the SCIE and Research in Practice for Adults (RiPFA) [Quality Markers for Safeguarding Adult Reviews](#) (June 2018, final Quality Markers published April 2022).
- 1.4 The SCIE and RiPFA quality markers covering three key working strands that encompass:
  1. Setting up a Review
  2. Running the Review
  3. Output, Action, and Impact

# 2. Introduction

- 2.1 The main purpose of this policy is to ensure that the DSAP is compliant with the legislative requirements as set out in Section 44<sup>1</sup> of the Care Act 2014 (the 'Act').
- 2.2 The duty to undertake a SAR rests with the Durham Safeguarding Adults Partnership (DSAP).
- 2.3 The 'Act' sets out the criteria for when the duty applies to the DSAP.
- 2.4 This policy aims to set out for agencies the criteria and purpose of SARs as well as the requirements upon agencies to make referrals where appropriate and participate in such reviews.
- 2.5 This policy should be read in conjunction with additional guidance outlined within [Chapter 14 of the Care and Support Statutory Guidance](#). Quality assurance and accountability arrangements in relation to SARs is included within this policy.
- 2.6 The policy should be utilised as a reference tool to support effective working between statutory and relevant partners of the DSAP, inform local decision-making processes and serve as a basis for best practice.
- 2.7 This policy does not replicate or replace individual organisation responsibilities for internal processes, as examples, [Serious Incidents](#), NHS National Reporting, Root Cause Analysis, Domestic Homicide Reviews, Individual Management Reviews.

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<sup>1</sup> <http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted>

- 2.8 There is an expectation that participative agencies use SARs as an opportunity to review, reflect and challenge their involvement and openly share to identify lessons and more importantly, address any improvement action identified.
- 2.9 The DSAP is committed to ensuring that all safeguarding adult policy is reflective of the six safeguarding principles:

**Empowerment** - presumption of person led decisions and informed consent

**Prevention** - it is better to take action before harm occurs

**Proportionality** - proportionate and least intrusive response appropriate to the risk presented

**Protection** - support and representation for those in greatest need

**Partnership** - local solutions through services working with their communities

**Accountability** - and transparency in delivering safeguarding

### 3. Legislation, Guidance and SAR Practice

- 3.1 Section 44 of the 'Act' instructs the DSAP of the circumstances of when to undertake a SAR.
- 3.2 The local authority must take the lead role and not delegate this statutory function. The local arrangement for reviewing and recommending a SAR sits with a group of decision-makers for each case; known as the SAR Panel.
- 3.3 In addition, the DSAP may request a person to supply information (Section 45 of the 'Act') to it or to another person. The person who receives the request must provide the information if:
- i. The request is made in order to enable or assist the DSAP to do its job in respect of the SAR
  - ii. The request is made of a person who is likely to have relevant information
- 3.4 SARs will not be effective in identifying learning or good practice without the sharing of information.
- 3.5 Section 6 of the 'Act' outlines a duty to co-operate generally with local authorities and relevant partners. Specific safeguarding adult clauses that apply under that section are:
- d) protecting adults with needs for care and support who are experiencing, or are at risk of, abuse or neglect, and
  - e) identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect and applying those lessons to future cases.
- 3.6 Section 81 of the 'Act' outlines the Duty of Candour<sup>2</sup> requirements. This is required as part of Care Quality Commission registration. This places a requirement on providers of health and adult social care to be open with people when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the normal standard in all organisations. With respect to SARs the DSAP will operate with transparency in relation to any service, organisation and/or

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<sup>2</sup> <http://www.legislation.gov.uk/ukpga/2014/23/section/81/enacted>

individual accountability and consider the interface with wider processes for example, disciplinary procedures and/or notification to professional bodies, regulators.

- 3.7 Parties to this policy should ensure they read in conjunction with the Locally Agreed Collaborative [Information Sharing Protocol](#) and in line with the Data Protection Act 2018, and General Data Protection Regulations (GDPR) when sharing information.
- 3.8 Examples of statutory and relevant partners include:
- NHS England
  - NHS Integrated Care Boards (ICBs) – formerly CCGs
  - Police
  - NHS Foundation Trusts (FT)
  - Department for Work and Pensions (DWP)
  - His Majesty’s Prison and Probation Services (HMPPS)
  - General Practitioners/Primary Care
- 3.9 Other agencies have the potential to act as relevant partners during any review and this can include Service Providers, Voluntary Sector organisations or education settings.
- 3.10 Learning from SARs highlights the importance of working together<sup>3</sup>, as a benchmark all agencies should be:
- a) Mindful of their own policy and guidance for undertaking investigations or enquiries into incidents prior to considering a referral for a SAR. (This is supportive of individual agency ownership and accountability).
  - b) Mindful to share information at the earliest opportunity where concerns may arise for providers of health and social care to support early identification and remedial actions. (This is supportive of collective ownership and accountability).
  - c) Mindful to consider and agree whether and what impartial information to share with adults, carers, families, or friends to assist them to make informed decisions about the services meeting their needs. (This is supportive of empowerment, choice and control, and the provision of relevant advice and information under the ‘the Act’).
- 3.11 SAR processes should be mindful of a focus upon learning that informs the wider preventative agenda. Being supportive of partnership approaches and the connection to prevention, early intervention and awareness raising, for example, links to the Health and Wellbeing Board, Durham Safeguarding Children Partnership, and Safe Durham Partnership.
- 3.12 On occasions where a partner or agency demonstrates a reluctance to or refuses to share the information requested, this should be made in writing. Any refusals to share information should be escalated the SAR Panel Chair and DSAP Chair. Agencies should contact the Board Business Unit for advice as needed.

## 4. The Purpose of a SAR

- 4.1 The purpose of carrying out a SAR 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

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<sup>3</sup> <http://www.hampshiresab.org.uk/wp-content/uploads/June-2014-Orchid-View-Serious-Case-Review-Report.pdf>

as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

- 4.2 Where it becomes apparent during the course of any review that serious concerns/issues relating to an agency or an individual involved in the case are suspected/evident, it may be necessary for further action(s) to be taken by the relevant agency, for example, disciplinary processes, referral to professional bodies.
- 4.3 The DSAP 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.
- 4.4 SARs should also be a means of exploring examples of good practice, particularly where this is likely to identify learning to apply to future practice/cases.
- 4.5 Any review undertaken should aim to:
  - a) Understand what has happened and why
  - b) Identify how the agencies and individuals could work together better and/or what they might have done differently to have prevented harm or death.
  - c) Learn and disseminate lessons from the way professionals and agencies worked together
  - d) Prevent similar harm occurring again in the future
  - e) Improve future practice by acting on the learning
  - f) Review and improve the Safeguarding Adults Policy and procedure
  - g) Identify good practice as well as issues of quality or poor practice

## 5. Criteria for a SAR

- 5.1 The Act and supporting guidance set out the criteria<sup>4</sup> for undertaking a SAR. The DSAP 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.
- 5.2 The DSAP 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. The SAR Panel will need to be mindful of any ongoing safeguarding enquiries.
- 5.3 In the context of a SAR, 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 as a result of the abuse or neglect (whether because of physical or psychological effects).
- 5.4 The adult who is the subject of any SAR does not have to be in receipt of care and support services for the DSAP to arrange a review.

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<sup>4</sup> Taken from the Care and Support Statutory Guidance (updated October 2018)

5.5 The DSAP is free to arrange for a SAR in any other situations (e.g. criteria not met) involving an adult in its area with needs for care and support. This may be the case where for example it is felt there would be potential learning for that case.

## 6. Involving Adults, Representatives and/or Families

6.1 For SARs to be effective, it is imperative to ensure an inclusive approach be adopted to each individual review process.

6.2 Section 68 of the 'Act' informs of the statutory duty where adults may have substantial difficulty to be involved in SARs an independent advocate should be sought to facilitate their involvement and ensure the adult is represented and supported.

6.3 Often, another agency may be better placed to assess whether an adult would have substantial difficulty to be involved in a SAR and require advocacy support. If it is felt that this is the case for an adult subject to a SAR, the referring agency should as standard consider whether the person:

1. Understands relevant information
2. Retains information
3. Uses or weighs up the information as part of engaging
4. Communicates their views, wishes and feelings

6.4 All referring agencies who feel the adult would have substantial difficulty to be involved in any SAR should make it clear on the [SAR referral form](#).

6.5 As standard all SARs should place a focus upon whether the adult, and/or family or friends should be involved. Where an adult has died or been seriously abused or neglected, consideration should be given to the involvement of family and/or representatives.

6.6 Family and friends and/or appropriate representatives should receive a copy of the family and friends leaflet when a SAR is agreed. Copies can be obtained from the [sabbusinessunit@durham.gov.uk](mailto:sabbusinessunit@durham.gov.uk) or by contacting 03000 268870.

6.7 The level of involvement and engagement with any SAR sits with the agencies/parties involved in decision-making (SAR Panel), this means those agencies/parties should consider:

- a) How the adult, family or appropriate representative should be informed
- b) Who will lead that engagement
- c) Identifying relevant family members to inform (particularly those who have played a significant role in the adult's life)

6.8 There is no 'one size fits all' approach to the involvement of adults or their representatives in SARs, and this is in keeping with a person-centred approach. Agencies will need to consider specifically the most appropriate way to involve family or representatives which may include:

- a) Formal notification only
- b) Extending invites to share views in writing or face to face to inform the review

- c) Extending invites to share opinions on specific elements included within the Terms of Reference of any review (with relevance and endorsed by the DSAP Chair).

6.9 Agencies/parties involved in decision making for SARs should also be mindful of any support needs for any family member(s) or appropriate representatives during a SAR process and consider their views in relation to publicising completed reviews.

## 7. Involving Practitioners

7.1 The DSAP should as standard practice ensure that all SARs include appropriate involvement of professionals and organisations who were involved with the adult.

7.2 It is vital, if individuals and organisations are to be able to learn lessons from any SAR processes that they should be trusted and safe experiences. They should encourage openness, honesty, transparency and sharing of information to inform the process and learning.

7.3 Agencies involved in SARs should refer to the SAR Practice Toolkit for further guidance.

## 8. Proportionality and Review Types

8.1 The 'Act' brings opportunity for the DSAP to consider with some flexibility the type and model of review to undertake for any SAR.

8.2 Adoption of an appropriate methodology in relation to the complexity and individual circumstances of the review should take place.

8.3 Examples of review methodology adopted by the DSAP may include (not limited to):

- Individual Agency Reviews/Overview Report
- Learning Together (SCIE)/Learning Lessons
- Serious Incident Learning Process (SILP)
- Appreciative Inquiry (AI)
- Root Cause Analysis (RCA)
- Peer Review
- Multi-Agency Desktop Review
- Safeguarding Practice Review (adapted from a Welsh model<sup>5</sup>)

## 9. Links/Interface with other reviews

9.1 At times, other reviews may already be taking place. Decision-making for SARs should consider any other parallel processes and what contributions may be required.

9.2 Other reviews or investigations that may run parallel include:

Coroner Investigations/Inquests

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<sup>5</sup> [https://www.sewsc.org.uk/fileadmin/sewsc/documents/Published\\_SCR\\_CPR/Child\\_Practice\\_Review\\_Guidance\\_-\\_Welsh\\_Government.pdf](https://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/Child_Practice_Review_Guidance_-_Welsh_Government.pdf)

Police and Criminal Justice Investigation

[Domestic Homicide Review](#)

[Mental Health Homicide Review](#)

[Multi Agency Public Protection Arrangements \(MAPPA\)](#)

[Child Safeguarding Practice Reviews \(formerly Serious Case Reviews\)](#)

[Leder -Learning from Life and Death Reviews Programme](#)

Individual Agency Disciplinary Procedures

Individual Agency Internal Reviews (for example, Serious Incidents, Root Cause Analysis)

- 9.3 It may be necessary to consider whether joint commissioning of reviews is of value, to reduce duplication of work for the organisations and families involved. This may apply in instances such as Child Safeguarding Practice Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews.
- 9.4 Agencies involved in decision-making will ensure due regard is given to ongoing police and criminal justice investigations including consultation and close liaison with relevant parties where needed for example, Senior Investigation Officer(s), Family Liaison Officer(s). It is important that the DSAP be mindful of any SAR action does not impact upon those investigations/parallel reviews.
- 9.5 Discussions between the Chairs of the SAR Panel and DSAP (and other relevant parties) should take place where parallel reviews are evident to establish whether any SAR should be delayed until the conclusion of those processes.
- 9.6 Any agency with knowledge of an adult who has died, and abuse or neglect is suspected and/or known (including domestic violence) should inform the police. The police will make a decision as to whether to notify the Coroner.
- 9.7 If an adult dies and abuse or neglect is suspected and/or known, and the adult is not known to safeguarding services, a S42 enquiry is not appropriate. In these instances, a report should be made to Social Care Direct (03000 267979) so it may be referred to the appropriate Officer to review and to assess any need for a SAR referral. The DSAP has a separate Coroner's Annex to this document as an additional guidance note.
- 9.8 If an adult dies following a SAR referral submission the decision-making agencies will agree upon any steps to inform the Coroner of any potential SAR.
- 9.9 It is usual in the event of a death that the Coroner process will take precedence to any SAR process. The DSAP business unit and Chair of any SAR Panel will liaise closely with the Coroner's Office as outlined in the DSAP Coroner Protocol.
- 9.10 Agencies should be mindful that final SAR reports can be requested by the Coroner and shared to inform Coroner processes. Should a request from the Coroner be submitted to the DSAP to share a SAR report, the DSAP Business Unit should inform the relevant agencies in agreement with the Chairs of the SAR Panel and DSAP.
- 9.11 In addition to the above non-statutory reviews known as LeDeR reviews can have linkage to SARs. These are local reviews of deaths of people with learning disabilities.

- 9.12 LeDeR reviewers should liaise with the Local Area Contact for LeDeR for any such reviews where it is considered that abuse or neglect was a factor and there are concerns for how agencies have worked together.
- 9.13 The Local Area Contact will decide whether a SAR referral is required. Should a SAR be recommended by the SAR Panel, the SAR would take precedence (see Appendix 1).
- 9.14 A new statutory duty introduced under Section 24, <sup>6</sup>Police, Crime and Sentencing Courts Act 2022 for Offensive Weapons Homicide Reviews to be undertaken in certain circumstances. For the purpose of this protocol the new duty does not apply where Section 44 1) or 4) applies in relation to a SAR. However, where a SAR is agreed specific consideration should be given to the relevant review partners to include as part of the SAR.

## 10. Making a referral for a SAR

- 10.1 Any agency or individual can make a referral for a SAR e.g. Coroners, Members of Parliament, Elected Council Members and/or family. Referral forms are available from the [SABBusinessunit@durham.gov.uk](mailto:SABBusinessunit@durham.gov.uk) or by contacting 03000 268870.
- 10.2 Practitioners/professionals and/or volunteers should request the SAR referral form Ref: SAR002 by email to [sabsecured@durham.gov.uk](mailto:sabsecured@durham.gov.uk)
- 10.3 Practitioners/professionals and/or volunteers are encouraged to attend the [DSAP Training Programme](#) for Submitting SAR Referrals.
- 10.4 Family members and/or appropriate representatives should contact the Business Unit on 03000 268871/268870 or [sabsecured@durham.gov.uk](mailto:sabsecured@durham.gov.uk)
- 10.5 Referrers should receive confirmation of receipt of referral in writing from the DSAP Business Unit.
- 10.6 On receipt of a referral, the DSAP Business Unit has responsibility for updating SAR recording systems and for quality assurance of referrals.
- 10.7 Should issues of quality arise on receipt of referral for agency submissions the DSAP Business Unit will alert the referring agency in writing of areas to address.
- 10.8 The DSAP Business Unit will co-ordinate convening of a SAR Panel and request further information from agencies (SAR Practice Toolkit).
- 10.9 Families and/or appropriate representatives should receive a copy of the advice and information leaflet for SARs (this is a vital requirement when a decision to instigate a SAR is agreed).

## 11. Decision Making for a SAR

- 11.1 A panel of decision makers known as a SAR Panel hold the responsibility for reviewing information requested and provided by agencies and for deciding upon recommendations to the DSAP Chair.

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<sup>6</sup> [Police, Crime, Sentencing and Courts Act 2022 \(legislation.gov.uk\)](https://legislation.gov.uk)

- 11.2 Where a SAR Panel feels the **criteria are met** to instigate a review, they will make recommendation to the DSAP Chair to:
- 1) Instigate a SAR
  - 2) Suggest the model to adopt
  - 3) Suggest any author requirements
- 11.3 Where a previous SAR has identified learning of value and another case with similar theme arises and criteria is met, the local SAR panel may give additional consideration to the flexibility of the model and any remit of a new SAR. They should explore specifically where learning is needed. This approach may also be applied to instances where the criteria is not met, to support a proactive approach to learning to support a shift away from reactive practice.
- 11.4 Where the '**criteria are not met**' for a SAR. The SAR panel may identify that there is some potential learning and can recommend/suggest:
- 1) An individual agency/management review
  - 2) A serious incident process
  - 3) A reflective session (considering independent facilitation)
  - 4) A single agency or DSAP audit activity
- 11.5 The DSAP Chair holds final responsibility for decision making for SARs and whether they agree the criteria has been met.
- 11.6 In line with the DSAP agreed arrangements, Durham County Council Legal Services act in an advisory role. Legal advice may be sought on this basis, and in certain circumstances it may be more appropriate to seek independent legal advice.

## 12. Disagreements

- 12.1 The DSAP Chair may disagree with the recommendation of a SAR Panel (see Appendix 2). In these instances, the DSAP Chair may request further information or suggest the SAR Panel reconvene and revisit the SAR referral.
- 12.2 The DSAP Chair at their discretion may seek advice of Chief Officers of relevant agencies in relation to informing decision making on recommendations of the SAR Panel.
- 12.3 In the above situations, where the recommendation of the SAR Panel is not accepted by the DSAP Chair, the SAR Panel should reconvene and review any feedback from the DSAP Chair. The SAR panel may re-submit any recommendation on endorsement and following any reconvened meeting and action taken.
- 12.4 If any DSAP member, involved agency or person disagrees with the recommendation of the SAR Panel and/or any endorsement of the DSAP Chair, an appeal can be made by contacting the DSAP Business Unit on 03000 268870.
- 12.5 The DSAP Board Business Manager will advise the agency or person on the format for submitting an appeal, in line with information sharing guidelines and the safe and secure transfer of information.

- 12.6 Following receipt of any appeal in writing, the DSAP Business Manager will liaise with the SAR Panel Chair and DSAP Chair to coordinate a review of the decision.
- 12.7 A response to any appeal should be sent in writing as soon as practicable.
- 12.8 The DSAP Business Unit will undertake any subsequent actions following any appeal as directed by the SAR Panel Chair and DSAP Chair.
- 12.9 If the appeal is not resolved to the agency/individual's satisfaction a complaint can be made to Durham County Council Adult and Health Services to: [AHSComplaints@durham.gov.uk](mailto:AHSComplaints@durham.gov.uk) or by contacting 03000 266855. Complaints to other agencies may also take place and this is dependent upon the nature of the complaint, as a rule, this may apply to any agencies/officers that are outside of the remit of the Local Government Ombudsmen.
- 12.10 The Local Government Ombudsmen is the organisation for onward reporting of any complaints/appeals if required.

### **13. Commencing a SAR**

- 13.1 Chief Officers of the key agencies e.g. Local Authority, Police, Integrated Care Boards (ICBs), formerly Clinical Commissioning Groups (CCGs) (not exhaustive) will receive confirmation in writing of the decision to proceed with a SAR by the DSAP Chair. At the same time, a request will be made to nominate a representative to undertake any tasks pertaining to the SAR on behalf of their agency.
- 13.2 Nominated representatives are expected to possess the appropriate levels of experience and seniority within their agency to participate in the SAR process.
- 13.3 The SAR Panel will have made recommendation as to whether to commission an independent author for any SAR. Should this be the case the DSAP will do so in line with Corporate Procurement Guidance of Durham County Council and in conjunction with the regionally agreed process for commissioning an Independent Author.<sup>7</sup>
- 13.4 SAR should by their nature bring value and maximum learning regardless of the circumstances, this will mean adoption of a flexible range of models appropriate to each individual case.
- 13.5 The SAR Panel will determine the scope of any review (see also Section 8) and draw clear Terms of Reference promoting the six safeguarding principles.
- 13.6 The SAR Panel will consider any support requirements for individual agency authors and/or participating agencies is standard practice.
- 13.7 Participating agencies of a SAR should take the necessary steps to secure records relating to the case to guard against loss or interference as soon as is practicable and in line with secure storage and transfer of information.

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<sup>7</sup> North-East Procurement Organisation – is the mechanism for tendering processes for commissioning a SAR author.

## 14. Timescales for a SAR

- 14.1 The DSAP should aim to complete SARs within 6 months of the decision by the DSAP to conduct a review wherever practicable. However, the complexity of a case may not become apparent until the review has started which may impact upon timescales for completion for example, ongoing parallel processes such as Coroner Inquests.
- 14.2 The DSAP should receive update of any barriers to progressing reviews in line with its agreed reporting arrangements.
- 14.3 Discussion between the DSAP Chair and SAR Panel Chair/Business Unit should take place regularly particularly in relation to timescales.
- 14.4 The completion of the review will also need to take account of any Coroner's Inquest and/or criminal investigations/proceedings.

## 15. Confidentiality and Consent

- 15.1 All agencies participating in SARs must ensure that information is kept confidential and in line with the Data Protection Act 2018 and UK GDPR.
- 15.2 Undertaking SARs is a statutory requirement placed upon DSAP's for cases that meet the criteria, and with that in mind, consent is not a barrier to proceeding with a SAR.
- 15.3 If an adult has died, it may be appropriate to inform the family or their appropriate representative (if known) of any decision that a SAR is to take place.
- 15.4 It should always be viewed as best practice to seek a view from the family or appropriate representative on whether they wish to be involved, however, *consent is not* required to instigate a SAR.
- 15.5 It is best practice to seek the consent of any living adult directly involved in a SAR to participate in the review and whether they consent to any family member(s) or appropriate representative involvement. Where this is not possible, the panel will consider seeking the consent of family/appropriate representatives to participate in the review.
- 15.6 Agencies should always consider UK GDPR and the Data Protection Act 2018 alongside the common law duty of confidence, and the rights within the Human Rights Act 1998, against the effect upon the adult(s) if they do not consent to share the information. The decision-making panel should pay particular attention to the wishes of an adult involved in a SAR. (Agencies should refer to the relevant information sharing guidance and toolkits accessible via the [DSAP website](#)).
- 15.7 The DSAP has a statutory obligation to undertake SARs. It should continue to be mindful of a sensitive approach to the adult(s) involved, families or their representatives, this includes ensuring a good understanding of the **relevance** of information shared pertinent to any SAR.
- 15.8 The DSAP will as standard report upon cases with anonymity unless otherwise requested by parties involved and agreed.

## 16. Quality Assurance and Accountability

16.1 The DSAP holds a responsibility for ensuring the quality of SAR reports and processes.

SAR reports should:

- Provide a sound analysis of what happened and why
- What action needs to be taken to prevent a reoccurrence (if possible).
- Be written in plain English.
- Contain findings of practical value to organisations, professionals, adult(s) involved and their families/representatives.
- Contain evidence of involvement of practitioners, professionals, adult(s) involved and their families/representatives (with specification consideration personalised approaches to their involvement for example, social care, health, cultural needs<sup>8</sup>)

16.2 Service specifications for the commissioning of SAR authors include quality assurance and reporting. Commissioning of authors responsibility rests with the DSAP and through local authority procurement arrangements.

16.3 The Care Quality Commission will receive all information pertaining to any regulatory functions and registered providers that arise during the course of a SAR.

16.4 The DSAP will adopt the SCIE and Research in Practice for Adults (RiPFA) quality markers for undertaking Safeguarding Adult Reviews. These quality markers serve as a benchmark to support the quality of SAR processes and subsequent SAR reports.

16.6 The DSAP holds a responsibility for undertaking audit activity on behalf of the DSAP. The DSAP may direct any audit it deems appropriate in relation to SARs. The regional Safeguarding Adult Review Champions network gives opportunity for peer review activity in respect of Safeguarding Adults Reviews and against National SAR Quality Markers.

16.7 Information shared by agencies for the purpose of any SAR is owned by the DSAP.

16.8 A SAR's main focus should be upon embedding learning and improving practice, this requires a partnership response to the prevention and protection of adults at risk of abuse or neglect.

16.9 A SAR explicitly should not focus on blame of any service, agency or individual, however agencies are expected to own the learning and findings with accountability to the DSAP.

## 17. Completion of a SAR and Publication

17.1 There is no statutory requirement to publish a SAR report. As best practice the DSAP will review SARs on a case-by-case basis and agree any publication requirements, a rationale for any agreement not to publish will be recorded.

17.2 It may in some instances be appropriate to produce an anonymised Executive Summary for certain cases. If such a document is to be produced, publication will need to be timed in accordance with the conclusion of any related court proceedings.

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<sup>8</sup> Analysis of Safeguarding Adults Reviews 2017-2019 – Findings for Sector Led Improvement

- 17.3 Involving adults, families and/or representatives may also inform any publication requirements for example, anonymising the final report and seeking agreement to publicise.
- 17.4 There is a statutory requirement to ensure the number of SARs that have taken place be included within the DSAP annual report. Where actions have not been implemented the DSAP must report upon those in the annual report.
- 17.5 The DSAP is committed to sharing SAR reports with the regional and national SAR Library (National Network for Chairs of Safeguarding Adults Boards). The DSAP will decide upon which cases may be included within each SAR library with the agreement of the adult(s), their family and/or representative and the DSAP Independent Chair.

## 18. Acting on the learning from SARs

- 18.1 SARs of value should demonstrate clearly the lessons identified and act upon that learning.
- 18.2 The DSAP in ensuring the maximum benefit of any SAR lessons should ensure:
1. Identification of what is unique to the case and context, and what can be used to apply to future practice, including good practice (the findings)
  2. Identify what remedial action needs to occur to help prevent similar harm in future cases (the outcomes)
  3. Consider how messages from the case should be shared and monitored (the impact).
- 18.3 When considering the outcomes of SARs any resulting action plans should be clear and achievable, they should be SMART.
- **Specific** – clear and focussed issues.
  - **Measurable** – clear indications of what the expected outcome should be.
  - **Achievable and/or Appropriate** – clear outline of what is needed included resources.
  - **Relevant and/or Realistic** – clear links that inform or can translate to practice and policy.
  - **Timely** – clearly prioritised actions and timescales.
- 18.4 At the heart of any SAR should be a focus on the adult(s), their family, or their representatives. It should be mindful of what the process feels like to them and how their involvement will contribute to any learning.
- 18.5 The DSAP Business Unit has responsibility for monitoring and update of the action plans from SARs. Reporting any concerns regarding progress of agency actions to the DSAP Safeguarding Adults Review Panel and ultimately the DSAP.
- 18.6 Consideration should be given to any links to wider working groups of the DSAP (for example, Learning and Improvement Group).
- 18.7 Each SAR will differ in the approach to disseminating the learning but can include:
- Multi-Agency Learning events
  - DSAP/Individual Agency Practice Briefings
  - Bespoke Training Programmes
  - Reflective Team Sessions/Supervision
  - 7 Minute Briefings by Authors

## 19. Record Keeping and Retention of Records

- 19.1 The DSAP has developed a suite of standardised templates to ensure a robust and consistent approach to record keeping for SARs. These are available to agencies in the SAR Practice Toolkit on request from the DSAP Business Unit. Those templates have been revised in line with published learning from the National Analysis of Safeguarding Adults Reviews 2017-2019, Local Government Association (December 2020) and sector led improvements recommendations specific to DSAP SAR activity.
- 19.2 Each organisation must ensure they adhere to their own internal record keeping and retention in relation to data.
- 19.3 Each agency will be requested to sign up to a confidentiality agreement at each meeting for SAR cases.
- 19.4 The DSAP as owner of the information gathered from agencies for the purpose of any SARs also holds responsibility for storage and retention of SAR reports.
- 19.5 SAR reports do not form part of individual client records for any agency.
- 19.6 Requests for SAR reports should be referred to the DSAP Business Unit (see Section 20). Any related documentation and/or data shared by other agencies is not held once a SAR report is complete.
- 19.7 With changes to the Data Protection Act 2018 and UK GDPR, the DSAP will retain records as below in line with [DSAP privacy notice](#).

## 20. Contacts and Further information

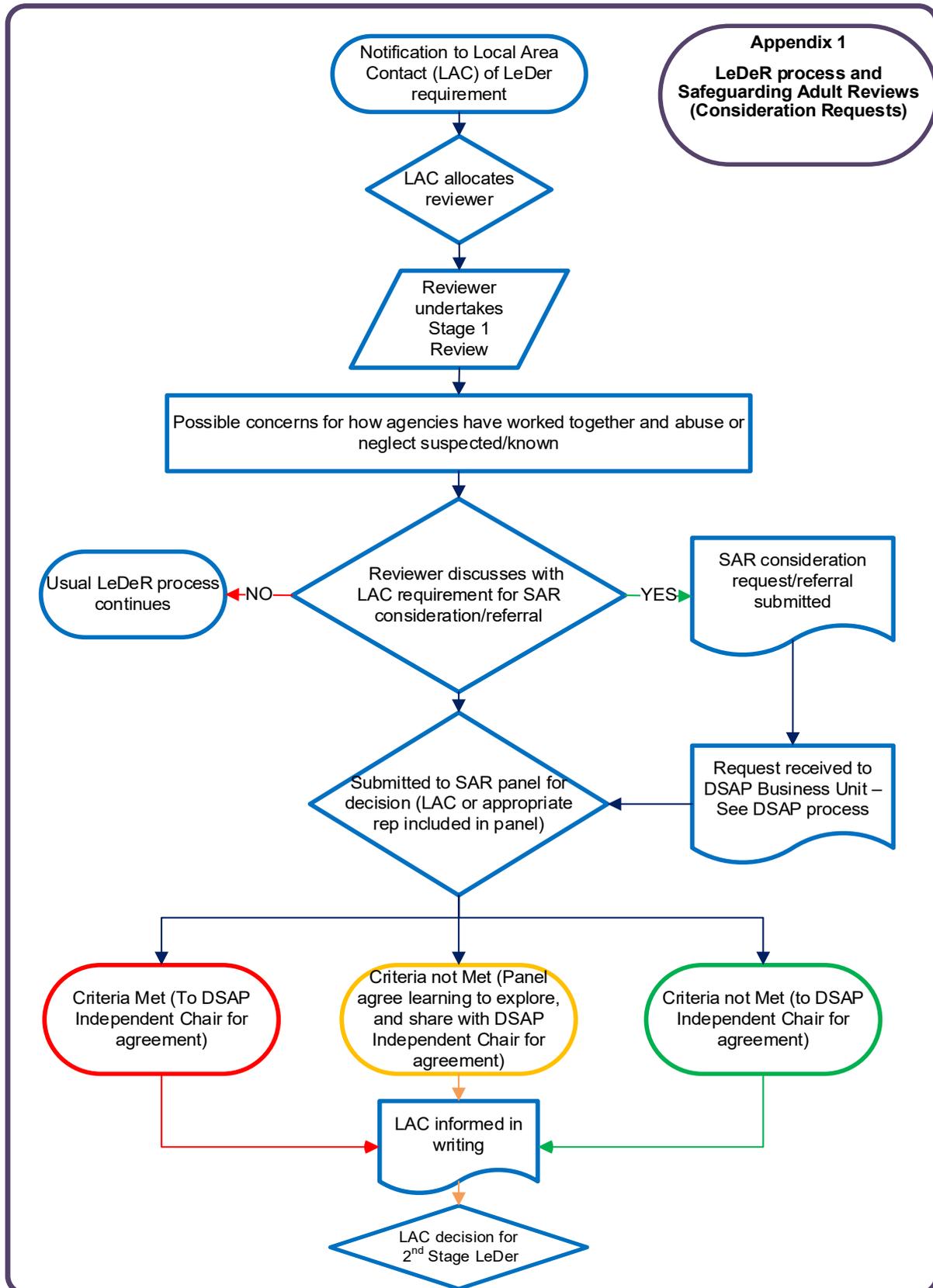
- 20.1 The DSAP Business Unit is the point of contact for any queries relating to locally agreed multi-agency policy and procedures.
- 20.2 All queries including any queries relating to appeals to decisions for SARs should be directed to the DSAP Business Unit in the first instance.
- 20.3 General or telephone queries should be directed to:

For the attention of:  
Durham Safeguarding Adults Partnership  
2/37,  
County Hall,  
Durham  
DH1 5UL

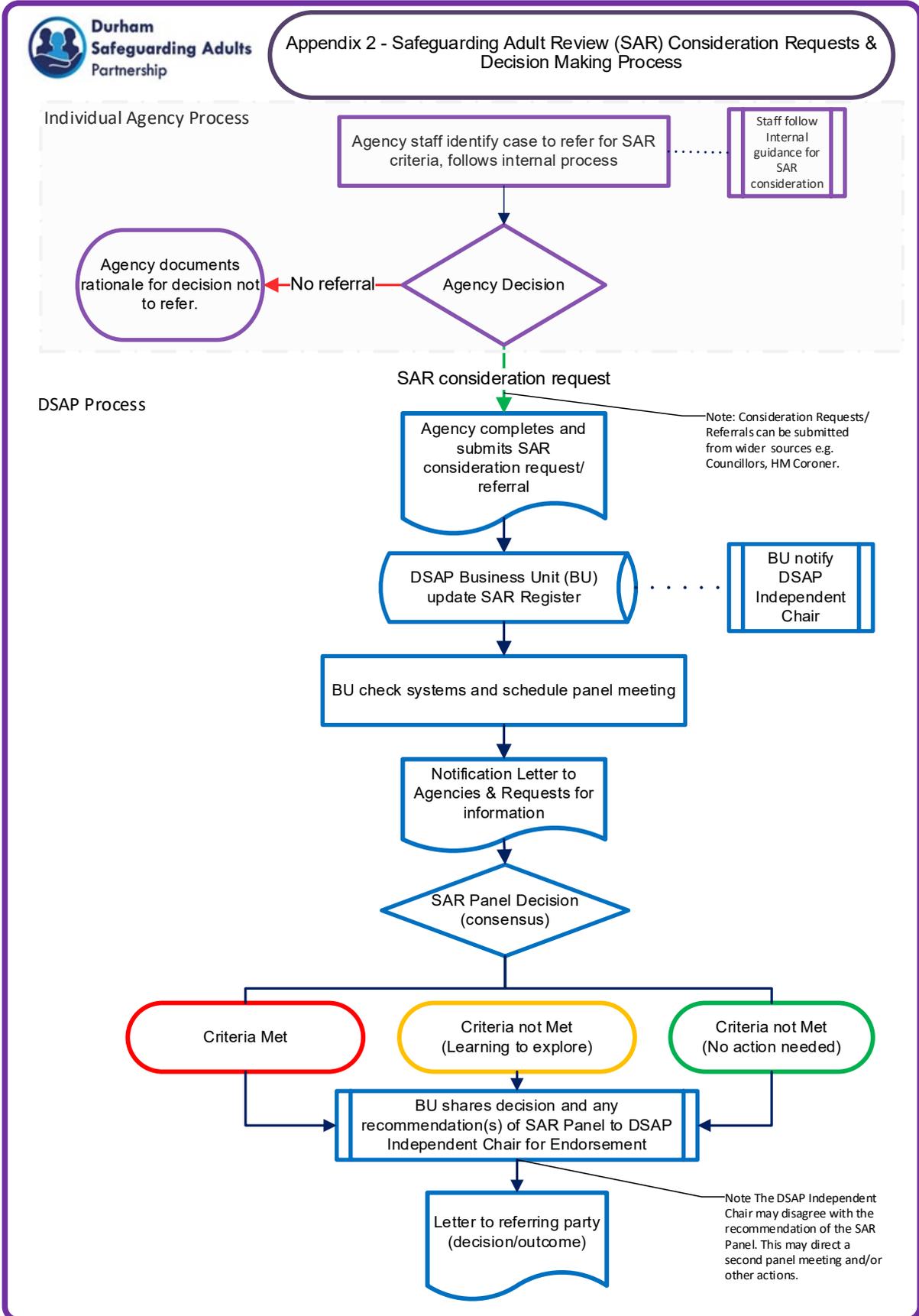
or [sabbusinessunit@durham.gov.uk](mailto:sabbusinessunit@durham.gov.uk) or 03000 268870/268871

- 20.4 If a query is sensitive or confidential, please ensure you mark all correspondence appropriately. Alternatively, you can contact the Unit on the number provided above for advice and information on forwarding requests or email [sabsecured@durham.gov.uk](mailto:sabsecured@durham.gov.uk)

# Appendix 1



# Appendix 2



## References

All accessed online 20 February 2023

Care Act (2014) c23, s6, s42, s44, s45 and Schedule 2 Available at:  
<https://www.legislation.gov.uk/ukpga/2014/23/contents>

Care and Support Statutory Guidance issued under the Care Act. Department of Health and Social Care  
[Care and support statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/care-and-support-statutory-guidance)

Department of Health (2011), *Statement of Government Policy on Adult Safeguarding*, London, DOH.  
<https://www.gov.uk/government/publications/adult-safeguarding-statement-of-government-policy-10-may-2013>

London SABs (2012). *"Serious Safeguarding Adults Reviews: Guidance note on options for London."* Working Paper November 2012  
<http://londonadass.org.uk/wp-content/uploads/2015/12/Safeguarding-Adults-Reviews.pdf>

Local Government Association (2020), *An analysis of Safeguarding Adults Reviews 2017-2019 Findings for Sector Led Improvement*, LGA, December 2020  
[Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 \(local.gov.uk\)](https://www.local.gov.uk/publications/analysis-of-safeguarding-adult-reviews-april-2017-march-2019)

The Home Office (2016), *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, THO.  
<https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

Ending rough sleeping for good - cross government strategy (2022)  
[Ending rough sleeping for good - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/strategies/ending-rough-sleeping-for-good)

NHS England, *Learning from Patient Safety Incidents*,  
<https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/>

Social Care Institute for Excellence (2022), *Safeguarding Adults Review Quality Markers*, (2022), London, SCIE. <https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers>

Social Care Institute for Excellence (2022), *Safeguarding Adults Reviews*  
[Safeguarding Adults Reviews \(SARs\) - SCIE](https://www.scie.org.uk/safeguarding/adults/reviews)

Social Care Institute for Excellence (2015), *Safeguarding Adults Reviews under the Care Act: implementation support*, London, SCIE.  
<https://www.scie.org.uk/safeguarding/adults/reviews/care-act>

The Association of Directors of Adult Social Services (2005), *Safeguarding Adults A National Framework of Standards for good practice and outcomes in adult protection work*, London, ADASS.

<https://www.adass.org.uk/adassmedia/stories/publications/guidance/safeguarding.pdf>

The Association of Directors of Adult Social Services (2010), *Vulnerable Adult Serious Case Review Guidance- Developing a local protocol*, London, ADASS.

<https://www.adass.org.uk/adassmedia/stories/safeguarding%20adults/vulnerable%20adult%20serious%20case%20review%20guidance%20final2%20dec%202006.pdf>

The Care Quality Commission (2018), *Statement on CQC's role and responsibilities for safeguarding children and adults*, CQC.

[https://www.cqc.org.uk/sites/default/files/20190621\\_SC121706\\_CQC\\_statement\\_February\\_2018\\_v3\\_0.pdf](https://www.cqc.org.uk/sites/default/files/20190621_SC121706_CQC_statement_February_2018_v3_0.pdf)

The Department for Education (2018) *Working Together to Safeguard Children (2018), A guide to inter-agency working to safeguard and promote the welfare of children*, DfE.

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>