



Safeguarding Adult Review (SAR) Process

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The SAR Process supports the Adult Safeguarding London Policies and Procedures and sets out the London Borough of Barking and Dagenham's approach to commissioning and undertaking a Safeguarding Adult Review (SAR).

Section 44 of the Care Act 2014 stipulates that Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area with care and support needs 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. SABs must also arrange a SAR if an adult with care and support needs, 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 was likely to have died but for an intervention, or 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 may arrange for a SAR in any other situations involving an adult in its area with care and support needs, whether or not they are being met by the Local Authority. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from 'near misses' and situations where the arrangements worked especially well. The SAB decides when a SAR is necessary, arranges for its conduct and if it so decides, implements the findings.

The criteria are met when:

- an adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- an adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect; and one of the following:
 - Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
 - Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
 - Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.

Where the SAB agrees that a situation does not meet the criteria but agencies will benefit from a review of actions, other methodologies can be considered. These include:

- Serious Incident Review: Organisations should use their own Serious Incident Procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations.
- Management Review: A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue.
- Reflective Practice Session: The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead or other such suitable person, including an independent facilitator.
- Learning Together: A collaborative scrutiny approach to a case

Requesting a Safeguarding Adult Review (SAR)

Any individual, agency or professional can request a SAR. The request should detail:

- What happened, with dates if known;
- The views of the adult/family/carer;
- Where the incident/concerns took place;
- Who was involved and their organisation and
- Why the request is being made.

The request should be considered against the criteria in order for a SAR process to be consistently applied.

Agreement to a SAR should be recorded on relevant systems across the statutory agencies. For the NHS this will be carried out by the CCG who will record on STEIS.

The Request for a SAR should be made to the SAB chair who will ask the Chair of the SAR Committee to:

- Notify statutory partners
- Request information from partners in preparation for a SAR panel meeting (this should be held within 4 weeks of the incident)
- Ask statutory SAB members and senior officer (where the organisation is not represented on the SAB) to nominate a person from their organisation to represent them on the SAR panel (see appendix 1 for SAR Panel Approval Form which must be completed).
- Convene a SAR panel meeting to include Adult Social Care, Clinical Commissioning Group, Borough Police and representatives of any other organisations relevant to the review. The Independent chair of the SAB will be invited as an observer to hear the issues and debate.

Partners will be invited to bring all relevant information to the panel to support decision making.

The panel will recommend their decision to the Chair of the SAB using the agreed template.

The SAB Chair will be asked to make a decision based on the SAR Panel's recommendation and complete the agreed template.

MAKING A DECISION ON SAR METHODOLOGY

Once the SAB Chair and panel of Board members have agreed to commission a SAR they must decide on the most appropriate methodology to use. How the SAR is conducted will affect the kind of learning obtained from it and whether the process is constructive and valuable. The choice of methodology is therefore significant and must be appropriate and proportionate to the case under review. The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

SAR chair – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience:

- Strong leadership and ability to motivate others
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
- Good analytical skills using qualitative data
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge
- Commitment to/ promotion of open and reflective learning cultures.

SAR Panel – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review, but should comprise a minimum of three members in addition to a chair with a level of independence from the case under review (see appendices 1 and 2 for relevant forms for appointing a member of a SAR panel, and indicating panel members' approval of the final SAR report).

Terms of reference – published and openly available.

Early discussions with the adult and their family, carers and friends – to agree to what extent and how they would like to be involved in the SAR, and to manage expectations. This includes access to independent advocacy if required

Appropriate involvement of professionals and organisations who were working with the adult – to contribute their perspectives without fear of being blamed for actions they took in good faith

SAR report and recommendations

Outside of these requirements, the methodology employed should be determined by and proportionate to the specific circumstances of the individual case. This implies SABs need a menu of review options to match against different cases.

A decision tree and a menu of options for SAR methodologies is provided on pages 6 to 11. Each methodology is valid in itself and no approach should be seen as more serious or holding more importance or value than another. 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.

The following should be considered in selecting a SAR methodology:

- Is the case complex, involving multiple abuse types and/ or victims?
- Is significant public interest in the review anticipated?
- Is large-scale staff/ family involvement wanted/ appropriate?
- Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained lead reviewers available in-house or nationally for the method selected? Are resources available to train or commission a lead reviewer?
- Can value for money be demonstrated?

In selecting a SAR methodology the LBBB SAB Chair and panel of Board members should aim for consensus, not a majority view. If the panel cannot come to a consensus, the final decision will rest with the Chair of LBBB SAB after carefully considering the views of all panel members.

In addition to selecting a SAR methodology, the Chair of LBBB SAB and panel of Board members must also decide:

- Which agencies (including legal, communications and CQC as required) should be asked to participate in the SAR panel.
- Level of independence from the case required of panel members (it is advisable that panel members have not had involvement in the case nor line management responsibility for staff writing a report for the SAR).
- Whether agencies are required to secure their files/ records.
- Level of independence required of the SAR chair (e.g. representative from another agency, external consultant etc.)
- The Terms of Reference for the SAR including timescales for completion and how learning from the SAR will be disseminated and embedded.
- Who will secure any legal advice required.

- How the interface between the SAR and any other investigations or reviews will be managed.
- A communication strategy, including clarification about what information can be shared, when and where (conditions).
- A media strategy.
- What the arrangements for administrative and professional support are and
- How it will be paid for.
- The required output from the SAR (e.g. a report).
- Whether an independent author is required, and level of independence.

MENU OF OPTIONS FOR SAR METHODOLOGY

The menu of SAR methodologies⁶ set out below includes the following five options:

- Systems analysis
- Learning together
- Significant incident learning process
- Significant event analysis/ audit
- Appreciative inquiry

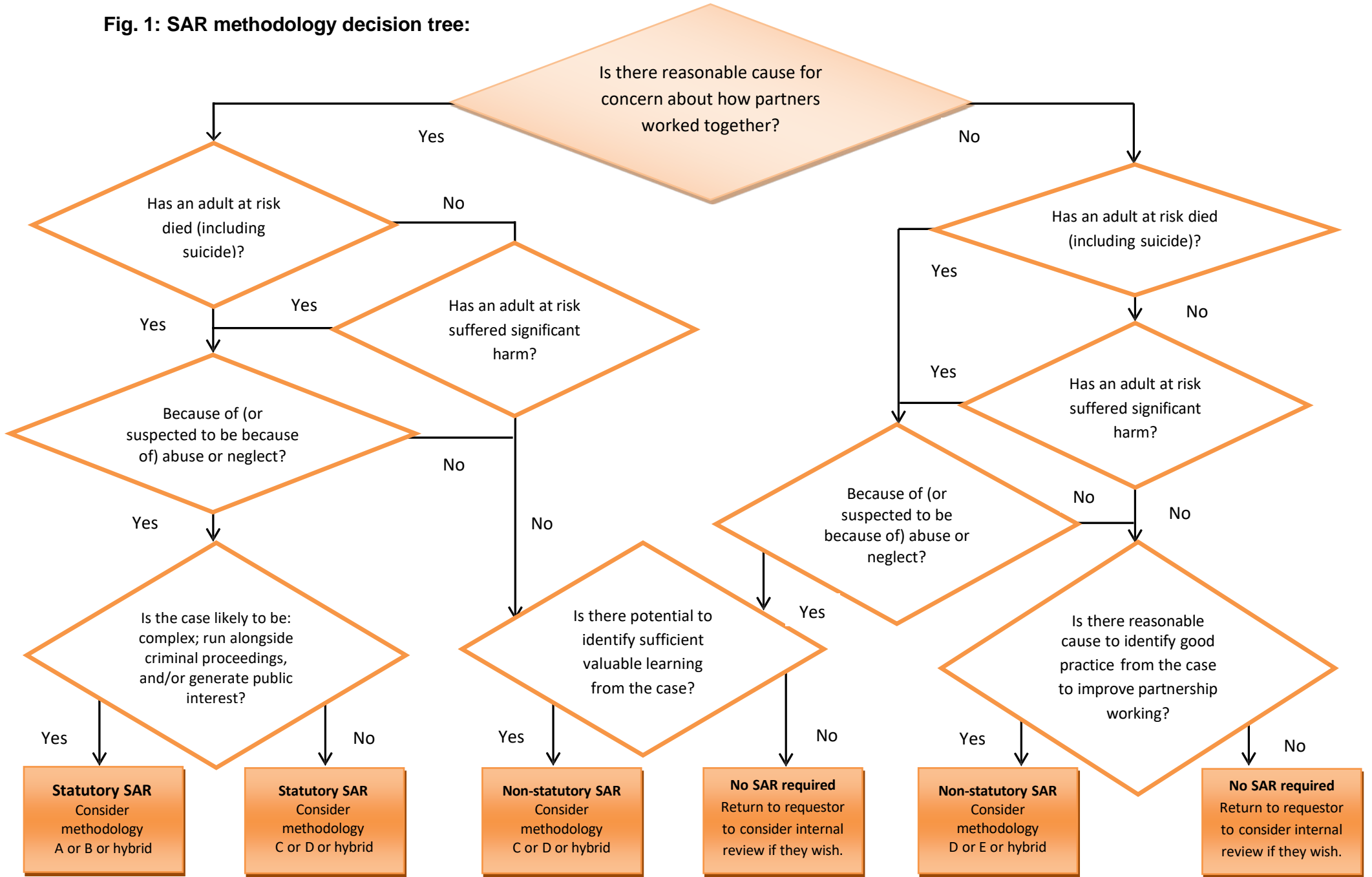
On the following pages, a process map of each methodology is provided, along with key features and advantages and disadvantages to assist decision-making. Links are provided to identified available models, which can be used for the most part to download tools and guidance in order to conduct a SAR according to the methodology.

The menu is not an exhaustive list. The Chair of LBBD SAB and panel of three Board members should use its collective experience and knowledge to recommend the most appropriate learning method for the case (including hybrid approaches).

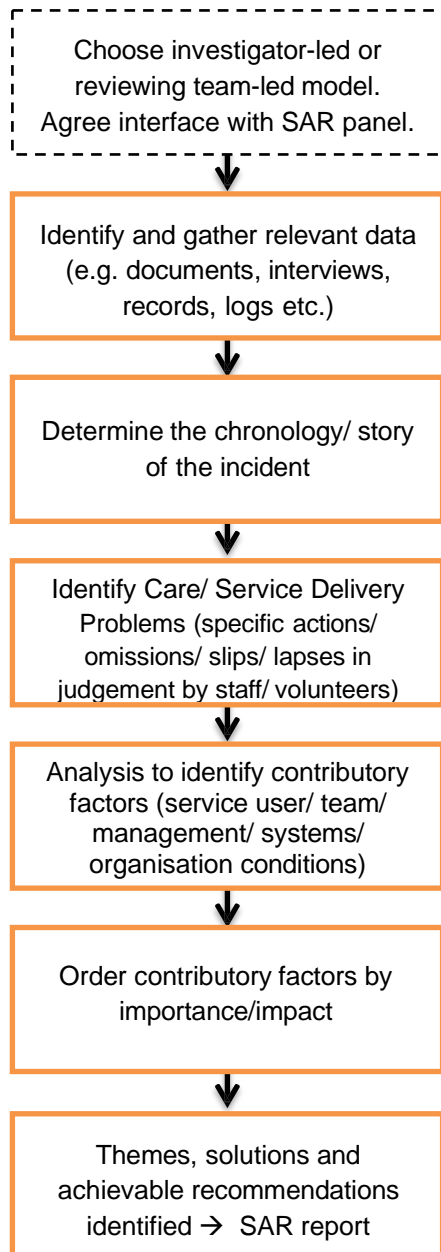
Once a methodology has been selected, all SAR panel members and others participating in a SAR will be fully briefed on the methodology to support them in carrying out their role. SAR panel chairs must not be too rigid or constrained by the methodology chosen – chairs may allow a degree of flexibility within each methodology, allowing SAR panel members to do things slightly differently where appropriate, in order to secure the maximum learning and benefit from the review.

Regardless of the methodology selected, all SARs should be completed within six months unless there are extenuating circumstances (e.g. potential to jeopardise police or court proceedings). SAR panel members should try to agree an appropriate timescale for the Review at the outset.

Fig. 1: SAR methodology decision tree:



Option A: Systems Analysis



Key features

- Team/ investigator led
- Staff/ adult/ family involved via interviews
- No single agency management reports
- Integrated chronology
- Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages

- Structured process of reflection
- Reduced burden on individual agencies to produce management reports
- Analysis from a team of reviewers may provide more balanced view
- Managed approach to staff involvement may fit well where criminal proceedings are ongoing
- Enables identification of multiple causes/ contributory factors and multiple causes
- Range of pre-existing analysis tools available
- Focusses on areas with greatest potential to cause future incidents
- Based on thorough academic research and review
- RCA tried and tested in healthcare and familiar to health sector SAPB members.

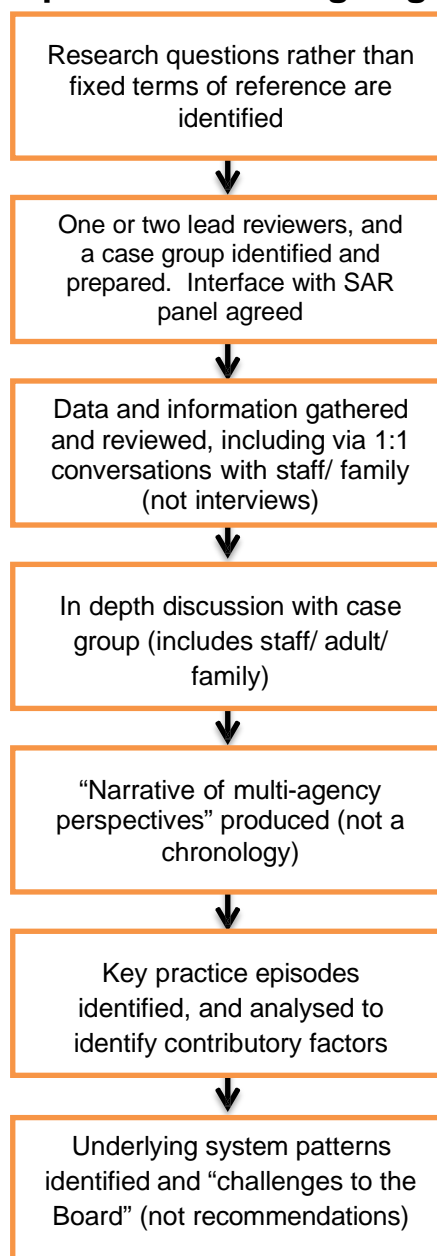
Disadvantages

- Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
- Staff/family involvement limited to contributing data, not to analysis
- Potential for data inconsistency/ conflict, with no formal channel for clarification
- Unfamiliar process to most SAPB members
- Trained reviewers not widely available
- Structured process may mean it's not light-touch
- RCA may be more suited to single events/incidents and not complex multi-agency issues

Available models:

Vincent et. al. (2003) [Systems analysis of clinical incidents: the London Protocol](#)
 Woloshynowych et. al. (2005) [Investigation and analysis of critical incidents](#)
 NHS National Patient Safety Agency (NPSA) [Root Cause Analysis](#)

Option B: Learning Together



Key features

- Lead reviewer led, with case group
- Staff/ adult/ family involved via case group and one to one conversation
- No single agency management reports
- Integrated narrative; no chronology
- Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions

Advantages

- Structured process of reflection
- Reduced burden on individual agencies to produce management reports
- Analysis from a team of reviewers and case group may provide more balanced view
- Staff and volunteers participate fully in case group to provide information and test findings
- Enables identification of multiple causes/ contributory factors and multiple causes
- Tried and tested in children's safeguarding
- Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity
- Range of pre-existing analysis tools [available](#)

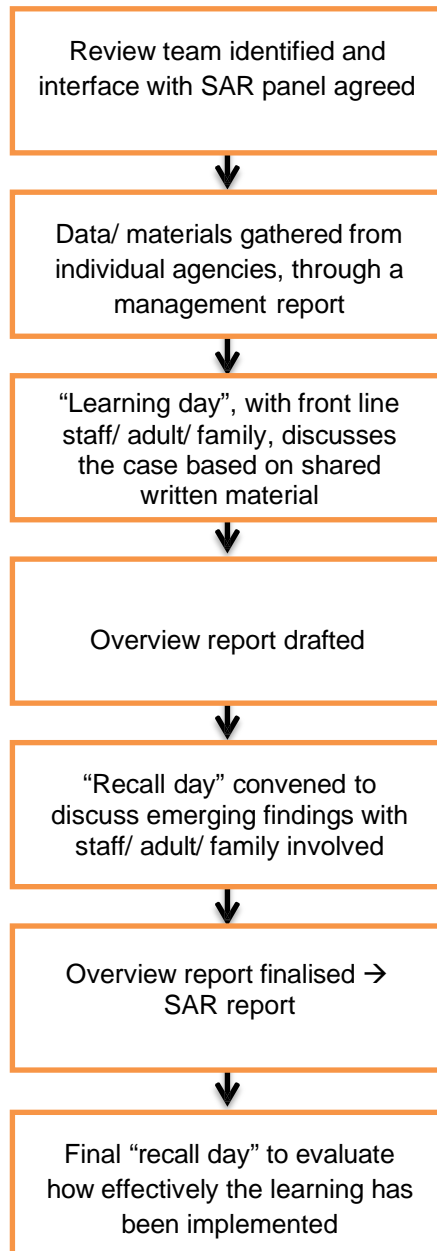
Disadvantages

- Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions
- Challenge of managing the process with large numbers of professionals/ family involved
- Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
- Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR
- Opportunity costs of professionals spending large amounts of time in meetings
- Unfamiliar process to most SAPB members
- Structured process may mean it's not light-touch

Available model:

SCIE, [Learning Together](#)

Option C: Significant Incident Learning Process



Key features

- | | |
|--|---|
| <ul style="list-style-type: none"> • Team/ investigator led • Staff/ adult/ family involved via interviews • No single agency management reports • Integrated chronology | <ul style="list-style-type: none"> • Multiple learning days over time • Explores the professionals’ view at the time of events, and analysis of what happened and why |
|--|---|

Advantages

- Flexible process of reflection – may offer more scope for taking a light-touch approach
- Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants
- Has similarities to traditional SCR approach, so more familiar to most SAPB members
- Agency management reports may better support single agency ownership of learning/ actions
- Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity

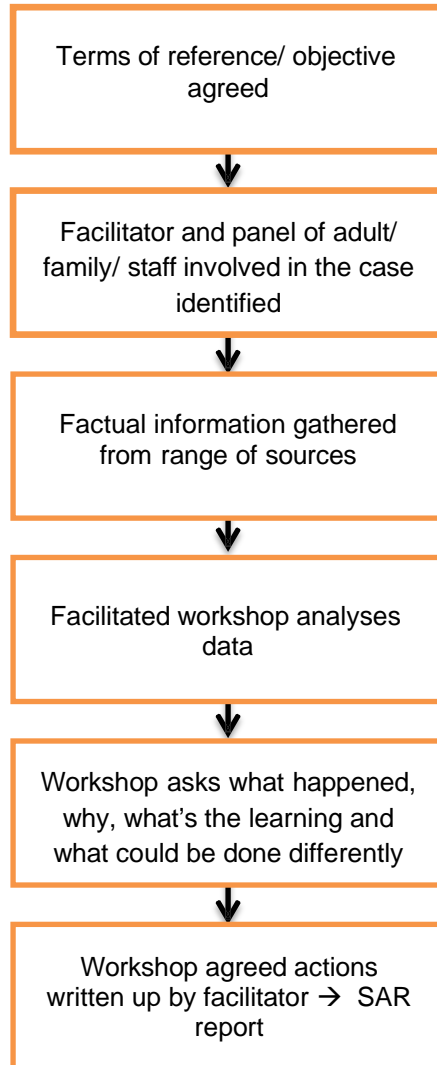
Disadvantages

- Burden on individual agencies to produce management reports
- Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR
- Opportunity costs of professionals spending large amounts of time in learning days
- Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses
- Not been widely tried or tested, nor gone through thorough academic research/ review

Available model:

Tudor, [Significant Incident Learning Process](#)

Option D: Significant Event Analysis



Key features

- | | |
|--|---|
| <ul style="list-style-type: none"> • Team/ investigator led • Staff/ adult/ family involved via interviews • No single agency management reports • Integrated chronology | <ul style="list-style-type: none"> • Multiple learning days over time • Explores the professionals' view at the time of events, and analysis of what happened and why |
|--|---|

Advantages

- Light-touch and cost-effective approach
- Yields learning quickly
- Full contribution of learning from staff involved in the case
- Shared ownership of learning
- Reduced burden on individual agencies to produce management reports
- May suit less complex or high-profile cases
- Trained reviewers not required
- Familiar to health colleagues

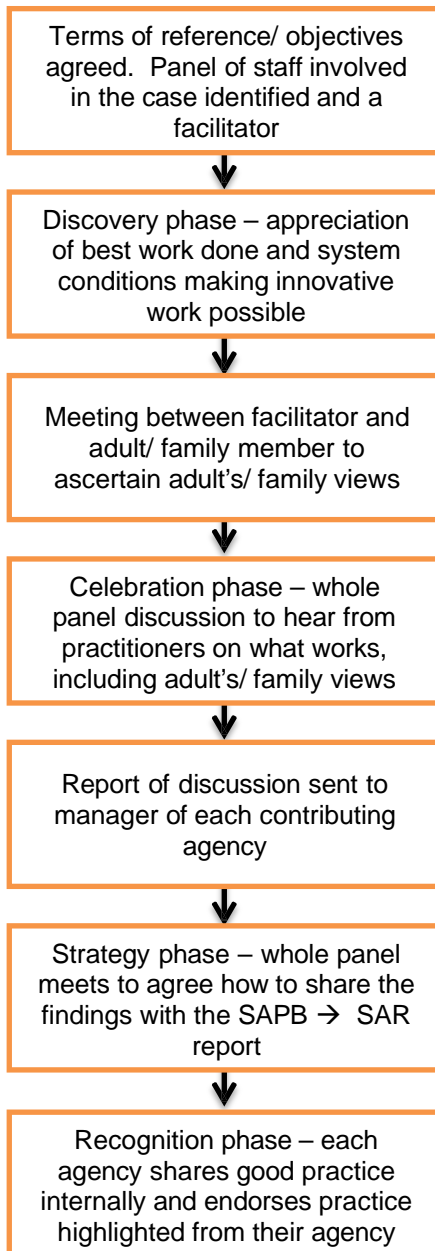
Disadvantages

- Not designed to cope with complex cases
- Lack of independent review team may undermine transparency/ legitimacy
- Speed of review may reduce opportunities for consideration
- Not designed to involve the family
- Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses

Available models:

NHS Education for Scotland and NPSA, [Significant Event Analysis](#)
 Care Quality Commission, [Significant Event Analysis](#)
 Royal College of General Practitioners, [Significant Event Audit](#)

Option E: Appreciative Inquiry



Key features

- Panel led, with facilitator
- Staff involved via panel. Adult/ No family involved via meeting single
- No chronology/ management reports
- Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Advantages

- Light-touch, cost-effective and yields learning quickly – process can be completed in 2-3 days
- Staff who worked on the case are fully involved
- Shared ownership of learning
- Effective model for good practice cases
- Some trained facilitators available
- Well-researched and reviewed academic model
- Model understood fairly widely

Disadvantages

- Not designed to cope with 'poor' practice/ systems 'failure' cases
- Adult/ family only involved via a meeting
- Speed of review may reduce opportunities for consideration
- Model not well developed or tested in safeguarding. Minimal guidance [available](#)

Available models:

Julie Barnes, [A new model for learning from serious case reviews](#)
 Newcastle Safeguarding Children's Board, [Appreciative Inquiry Champions Group](#)

Timescales

The timescale from the decision to conduct a SAR to completion is six months. In the event that the SAR is likely to take longer for example, because of potential prejudice to related court proceedings, the adult/advocate and others should be advised in writing the reasons for the delay and kept updated on progress.

Task	Planned Date
Sub group meets to make decision to convene a SAR	Within two weeks of receipt of request
Reviewers commissioned	Within three weeks of the commission of the SAR
Initial Scoping Meeting with reviewers and SAR Panel	Within 2 weeks of commissioning reviewers
IMRs requested and interviews/meetings with key people	Following first meeting of reviewer and SAR Panel
SAR Panel meetings	Monthly throughout the process
Presentations of draft final report to SAR Panel	Five months from date of commission
Presentation to SAR Committee	Five and a half months from date of commission
Presentation of completed report to the SAB for sign off	Six months from date of commission
Sharing of the report with family members	Within two weeks of sign off
Publication	Seven months from date of commission
Learning Event	Nine months from date of commission

The SAR Panel will meet monthly to:

- Review progress of the SAR.
- Identify immediate risks and address these.
- Identify learning that can be shared.
- Provide guidance to the SAR Independent Reviewer.
- Review draft reports.
- Agree and recommend the final draft report to the SAR committee and then the SAB.
- Review communications and media in light of emerging issues.

Approval of the final SAR report

The Independent reviewer will present the SAR to the SAR Panel for approval (see appendix 2 for SAR Panel Report Approval Form, which should be completed by all SAR Panel participants at the Panel meeting at which the final SAR report is agreed.

Thereafter, the report will be presented to the SAR Sub-Group of the Safeguarding Adults Board, and finally to the Safeguarding Adults Board itself for final approval to publish. Where an agency remains in dispute about a conclusion of the Safeguarding Adults Review, and this has been unable to be resolved to the satisfaction of the Independent Reviewer and the participating agency through the SAR Panel process, such dispute will be brought to the attention of the SAR Subgroup when the finalised report is presented for approval. The agency will have the opportunity to set out their disagreement, and the SAR Panel will take a final view based on their assessment of the recommendation of the Independent Reviewer.



The SAB will need to agree:

- Publication and associated media and communication strategy
- How the learning will be shared across the partnership
- Development of action plan and implementation
- Review of progress of action plan.

ADULT/ FAMILY INVOLVEMENT AND INDEPENDENT ADVOCACY

This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures, and Section 68 of the Care Act and associated statutory guidance.

Adults and/ or families should be invited and supported to contribute to SARs if they wish to do so, in order that an inclusive approach is taken and that their wishes, feelings and needs are placed at the heart of the review.

The SAR Panel chair must attempt to make contact with the adult(s), their family and/ or representatives early on (ideally before the first SAR panel meeting) to establish:

- Why and how a SAR will be undertaken into their (family member's) case.

- How they would like to be involved e.g. views contributed via telephone conversation, or interview, or attendance at SAR meetings.
- Any support or adjustments they would need to facilitate their involvement.
- Their initial views, wishes, concerns, and any answers/ outcomes they would like to achieve from the SAR.

Reasonable and appropriate support and adjustments should be made by LBBB SAB as required to enable the adult(s), their family and/ or representatives to participate in the SAR. This may include, but is not limited to:

- Easy read, large print and/ or translated materials.
- Access to an interpreter.
- Support from a chosen chaperone or representative.
- Longer meeting times
- Pre-meeting briefings and post-meeting de-briefs.
- Access to a statutory independent advocate.

If there is no appropriate person to support and represent the adult(s), then LBBB Council must arrange for an independent advocate (under Section 68 of the Care Act). Arrangements should be made in line with LBBB Council's standard policy and procedures for arranging advocacy.

Alternatively, if the relevant criteria are met, appropriate partners can arrange for an independent mental capacity advocate (IMCA) or an independent mental health advocate (IMHA) to support and represent the adult(s). If an independent advocate, IMCA or IMHA has already been arranged for the adult(s), e.g. during assessment and care support planning or for a safeguarding enquiry, then the same advocate should continue to be used.

It is for LBBB Council to form a judgement on a case by case basis about whether the adult(s) has "substantial difficulty" in being involved in the SAR process, and about who can act as an appropriate person.

STAFF INVOLVEMENT

This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers and their line managers. It should be made clear that the review process can be lengthy.

It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This

should include their views about what, in their opinion, could have made a difference for the adult(s) and/ or family. All agencies must support staff and practitioners involved in a SAR to “tell it like it is”, without fear of retribution, so that real learning and improvement can happen.

Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offered support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers, and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

PROFESSIONAL CONDUCT ISSUES ARISING

This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR panel to deal with these.

Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

QUALITY ASSURANCE OF THE SAR

Quality assurance is embedded throughout the SAR process, from commissioning through to SAB scrutiny of the report and implementation of recommendations. Quality assurance is also built into the SAR methodology options set out in this framework.

In each model it is imperative that SAR panel members avoid agency defensiveness and arguments about minute detail of what happened. The following arrangements will help to avoid/ minimise this:

- Commissioning the most appropriate SAR methodology for the case;
- Commissioning a suitably skilled, experienced and independent SAR lead or chair to facilitate the review and analysis.
- Independence of SAR panel members from the case under review.
- A focus in each model on seeking out causal factors and systems learning.
- Requirements in the terms of reference for the SAR to take a broad learning approach and to “tell it like it is”.

Finally, the contents of the report presented to the SAB (as set out in Appendix 5) must contain enough of the evidence, analytical techniques/ tools used and “working out” for

the SAB to be able to check, scrutinise and challenge. In doing so, the SAB will gain assurance of the adequacy of the evidence, quality of the analysis and usefulness of the recommendations, but will not duplicate the work already completed in the course of the SAR.

ACTING ON THE RECOMMENDATIONS OF THE SAR

LBBB SAB will translate learning from the SAR report into recommendations and a proposed multi-agency action plan if required, which should be endorsed at senior level by each organisation to whom it relates. The SAB may decide not to implement a recommendation(s), but must state the reason for that decision in its Annual Report.

The multi-agency action plan will indicate:

- The actions that are needed
- Responsibilities for specific actions
- Timescales for completion of actions
- The intended outcomes: what will change as a result
- Mechanisms for monitoring and reviewing intended improvements
- The processes for dissemination of the SAR report or its key findings.

Individual agencies may also be asked by the SAB to produce their own internal action plans if required.

Board members of LBBB SAB are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.

LBBB SAB will monitor progress on all recommendations (or delegate to an appropriate sub-group) and may request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

In line with Schedule 2 of the Care Act, LBBB SAB will include findings from any SARs in its annual report, and information on any ongoing SARs. The annual report will list for completed SARs what action was taken or is intended to be taken in relation to the findings, or where LBBB SAB decided not to implement a recommendation the reasons for that decision.

APPLYING LEARNING FROM NON-LBBB SARs

LBBB SAB is committed to the regular analysis of the themes and learning from nationally high-profile SARs and relevant other SARs as selected by the Safeguarding Adult Review (SAR) Committees.

The SAR Committee has an embedded process for the review of SARs from outside LBBB as part of their annual workplan to ensure lessons are identified, disseminated and embedded:

- The SAR Committee identifies key themes and learning from SARs outside of LBBB, and presents findings from a case to the Group following discussion with the chair.
- The Group reviews the themes and learning in the LBBB context to evaluate learning and identify any areas of improvement for LBBB
- The SAR presentation is disseminated to partners via their Group member for discussion and implementation of any single agency learning.
- Relevant multi-agency learning and actions identified are drawn together and presented to the SAB annually for discussion and consideration as part of the SAB strategic plan.

The SAR Committee may do whatever else seems necessary and reasonable to facilitate the dissemination and embedding of this learning into practice, for instance, facilitating a learning slot at a SAB meeting or away day, circulating e-newsletters, incorporating findings into training and workshops for staff etc.

SUPPORTING AND RESOURCING SARs

Section 44(5) of the Care Act requires each member of LBBB SAB to co-operate in and contribute to the carrying out of a SAR, with a view to:

- Identifying the lessons to be learnt from the adult's case, and
- applying those lessons to future cases.

Partners are required under Sections 6 and 7 of the Care Act to:

- co-operate in general in the performing of statutory functions under the Care Act that relate to protecting adults with needs for care and support and/ or carers from abuse and promoting their wellbeing, including SARs.
- co-operate when requested in relating to specific cases, such as SARs.

In addition, Section 45 of the Care Act places a duty on all partner organisations to supply information to LBBB SAB (or other specified person) where they are likely to have relevant information that will enable or assist the SAB in exercising its functions – including conducting SARs.

Resources are needed for undertaking and supporting a SAR. The statutory partners on the LBBB SAB will provide resources, in cash or kind, on a shared basis to ensure that the relevant costs for each SAR can be met. These will vary according to the methodology selected – e.g. a SAR requiring the services of consultants as independent chair and independent author will be more costly.

The statutory partners on the LBBB SAB will also ensure that the SAR chair and panel receive adequate administrative support, and will take a decision on how and from whom this will be provided.

All partners will commit internal resources to the production of evidence for a SAR (e.g. an IMR or interviews/ conversations with relevant staff) as requested by the SAR panel.

The Safeguarding Adults Business & Policy Manager will maintain an annual overview of SAR related costs for the SAB, for consideration each year as part of the annual report and to aid annual budgeting by partner organisations.

Reasonable and appropriate support and adjustments should be made by LBBB SAB as required to enable the adult(s), their family and/ or representatives to participate in the SAR. This may include, but is not limited to:

- Easy read, large print and/ or translated materials.
- Access to an interpreter.
- Support from a chosen chaperone or representative.
- Longer meeting times
- Pre-meeting briefings and post-meeting de-briefs.
- Access to a statutory independent advocate.

If there is no appropriate person to support and represent the adult(s), then LBBB Council must arrange for an independent advocate (under Section 68 of the Care Act). Arrangements should be made in line with LBBB Council's standard policy and procedures for arranging advocacy.

Alternatively, if the relevant criteria are met, appropriate partners can arrange for an independent mental capacity advocate (IMCA) or an independent mental health advocate (IMHA) to support and represent the adult(s). If an independent advocate, IMCA or IMHA has already been arranged for the adult(s), e.g. during assessment and care support planning or for a safeguarding enquiry, then the same advocate should continue to be used.

It is for LBBB Council to form a judgement on a case by case basis about whether the adult(s) has "substantial difficulty" in being involved in the SAR process⁹ and about who can act as an appropriate person.

Safeguarding Adult Review (SAR) Panel Nomination of representative to the SAR Panel

Name of SAR	
Date SAR Commissioned	
Name of SAR Panel Chair	

Responsibility of the statutory SAB member or senior officer (where the organisation is not represented on the SAB)

For all SAR panels a statutory SAB member, or other senior equivalent for organisations not represented on the SAB (confirmed to the SAB in each case), must agree and appoint a SAR Panel member to represent your organisation.

Responsibility of the SAR Panel Member

As a member of the SAR Panel you are agreeing to represent your organisation on the SAR and you agree to the following:

- To fully take part in the review
- To attend SAR Panel meetings and any other meetings related to this SAR
- To provide necessary information relevant to the review to the panel and/or independent reviewer, ensuring that this reflects your organisation's overall contribution to the review
- To share and disseminate information, findings and the recommendations of the review to your organisation
- To share and seek approval from the relevant colleagues, line manager, senior managers and where necessary your legal team, in your organisation, on the draft final report, prior to the panel signing it off.

Name of organisation	
Name of statutory SAB member or senior officer	
Job title	
Signature	
Date	
Name of Panel Member that you are appointing	
Job title	
Signature of panel member	

Appendix 2

Safeguarding Adult Review (SAR) Panel Report Organisational Approval Form

Name of SAR	
Name of SAR Panel Chair	
Date SAR Commissioned	
Date SAR report circulated for comment	
Deadline for comments on the SAR Report prior to finalisation for the Panel	

Name of organisation	
Name of SAR panel member	

<p>Report sign off process</p> <p>By signing below, you are indicating that, to the best of your ability and knowledge the report on the above-named Safeguarding Adults Review has all relevant information included pertaining to your organisation, and that you have taken steps to ensure that all relevant colleagues, including the statutory SAB member or equivalent senior manager who appointed you to the SAR Panel, are briefed on the SAR conclusions and recommendations.</p>	
Signature	
Date	