**BRIEF DESCRIPTION OF PROCEDURE:**

This document outlines the procedure and practice for the management of Safeguarding Adults Reviews in Luton

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**RELATED REFERENCE DOCUMENTATION**
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</tr>
</tbody>
</table>

Summary of changes made to last approved version
# Contents

1. **Introduction** 

2. **When should a Safeguarding Adults Review be held?** 

3. **Principles and purpose of a Safeguarding Adults Review** 

4. **The purpose of a Safeguarding Adults Review** 

5. **The approach used in Safeguarding Adults Review** 

6. **The process for managing a Safeguarding Adults Review** 

7. **Timeframe for a Safeguarding Adults Review** 

8. **Links with other review** 

9. **Procedure for making a referral for a Safeguarding Adults Review** 

11. **Procedure for referral of a Safeguarding Adults Review Board** 

12. **Procedure for commissioning a Safeguarding Adults Review** 

13. **Safeguarding Adults Review Methodologies and Recommendations** 

   - Methodologies 
   - Significant Event Analysis 
   - Using Individual Management Review to monitor performance 
   - Multi-agency combined chronology 
   - Traditional Serious Case Review 
   - Recommendation to the Independent Chair 

14. **Findings from Safeguarding Adults Reviews** 

15. **Roles and Responsibilities** 

16. **Governance** 

17. **Appendices 1-11**
1. INTRODUCTION

The purpose of this policy is to outline the process for undertaking a Safeguarding Adults Review (SAR) in Luton. The Safeguarding Adults Review Sub-group (also known as the SAR Panel) of the Luton Safeguarding Adults Board (LSAB) is responsible for recommending the commissioning of Safeguarding Adults Reviews, managing the process and assuring the LSAB that recommendations and associated actions have been addressed by the multi-agency partnership and individual agencies.

The work of the SAR Panel is governed by Section 44 of the Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted, which sets out the criteria and procedure each Safeguarding Adults Board should use when a Safeguarding Adults Review is required. This replaces the previous Luton Safeguarding Adults Board policy and guidance on carrying out Serious Case Reviews. Safeguarding Adults Reviews provide an opportunity to improve inter-agency working, through onward dissemination of lessons learnt to partner agencies, the sharing of best practice and ultimately better safeguarding of adults at risk of abuse or neglect.

Safeguarding Adults Reviews are not enquiries into how an adult at risk died or who is culpable; that is a matter for safeguarding investigations, Coroners or Criminal Courts to determine, as appropriate.

A Safeguarding Adults Review is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented by better partnership working.\(^1\) The Review uses that consideration to develop learning that enables Luton Safeguarding Adults Board to improve its services and prevent abuse and neglect in the future.

Agencies will have their own internal procedures to review practice and raise standards, through complaints, audits and serious incident investigations; As such, a Safeguarding Adults Review is not intended to duplicate those processes, nor to investigate allegations of abuse or neglect. Rather, the focus is on multi-agency learning through consideration of how agencies work together, with the intention of improving how they do so in the future.

This document will refer to the Luton Safeguarding Adults Board (LSAB) as “The Board”.

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\(^1\) 44 Safeguarding adults reviews (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if— (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,
2. WHEN SHOULD A SAFEGUARDING ADULTS REVIEW BE HELD?

The Board must arrange a Safeguarding Adults Review (SAR), in line with Section 44 of the Care Act 2014 where:

1. The Board has “reasonable concern” about how LSAB members worked together to safeguard the adult at risk and;
2. The adult has died 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.
or
3. The adult has not died, but the Board knows or suspects that the adult has experienced abuse or neglect.

The Board is free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

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.

3. PRINCIPLES OF A SAFEGUARDING ADULTS REVIEW

SARs should reflect the six safeguarding principles:

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** – The least intrusive response appropriate to the risk presented.
- **Protection** – Support and representation for those in greatest need.
- **Partnership Working** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding so that the adult knows and understands the role of everyone involved in their life.

4. THE PURPOSE OF A SAFEGUARDING ADULTS REVIEW

The purpose of a SAR is to ensure there is 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.
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, 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.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences which 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.

5. THE APPROACH USED IN SAFEGUARDING ADULTS REVIEWS

The approach taken in SARs' should be proportionate according to the scale and level of complexity of the issues being examined.

The Board 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.

The adult who is the subject of any SAR need not have been in receipt of care and support services for the Board to arrange a review.

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved and where required. Families should be invited to contribute to reviews. It is important that they are informed of how they are going to be involved and their expectations should be managed appropriately and sensitively.

There is also a separate duty to arrange an independent advocate for adults who are subject to a Safeguarding Adults Review (SAR).

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.
The Board also agrees that SARs should be carried out in a way that embeds the following into practice:

**Positive reflection**: the intention of Safeguarding Adults Reviews is to learn and improve services, not to blame any individual or specific agency and reviews will highlight positive and innovative practice as well as that which could have been different.

**Timeliness**: priority will be given to ensuring that timescales set out are adhered to and reviews are undertaken in timely manner. This will be considered at the point of commissioning.

**Impartiality**: the review will be conducted fairly and impartially with evidence of balance and objectivity in all reports.

**Thoroughness**: the review process is robust and committed to exploring each of the terms of reference in detail.

**Openness and accountability**: the review and its outcomes will be shared appropriately and the process will be conducted in accordance with the Board and member agencies’ governance arrangements.

**Sensitivity**: SARs will be sensitive to the diversity of adults at risk and those alleged responsible in terms of their circumstances and backgrounds (for example, in respect of their age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status).

**Confidentiality**: all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

6. **THE PROCESS FOR MANAGING A SAFEGUARDING ADULTS REVIEW**

The process for undertaking SARs should be determined according to the specific 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, providing 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 Board.

The Board should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult.

The SAR process should also communicate with and engage the adult and / or, their family.

In some cases it may be helpful to communicate with the person who caused the abuse or neglect.
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;
- Ways of working that promote an open, reflective learning culture.

7. **TIMEFRAME FOR A SAFEGUARDING ADULTS REVIEW**

The Board 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.

8. **LINKS WITH OTHER REVIEWS**

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.

In setting up a SAR the Board 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.

It may be helpful when running a SAR and DHR or child SCR in parallel to establish from 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.

9. PROCEDURE FOR MAKING A REFERRAL FOR A SAFEGUARDING ADULTS REVIEW

If, following a safeguarding enquiry under Section 42 of The Care Act 2014, it has been identified that a case meets the criteria for consideration of a SAR following a case conference; the referral proforma should be completed. See Appendix 1.

Any professional from the Board’s partner organisations, aware of an adult at risk who is not currently subject to a safeguarding enquiry, but who meets the criteria for a SAR can make a referral for a SAR using the referral form in appendix 1.

Completed referral forms should be sent to the Independent Chair of the Board, at

Referrals can also be made in writing by the Coroner, MPs and Elected Members of Luton Borough Council.

Other parties who consider a SAR is necessary should raise their concerns with the relevant member of the Board who can then advise and assist in making a referral.

The Board will consider commissioning/arranging a SAR when it is known or suspected that:

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

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

  **And**

- There are **clearly identified areas of learning and practice improvement or service development** that have the **potential to significantly improve** the way in which adults at risk of abuse and neglect are safeguarded in the future.
10. PROCEDURE FOR CONSIDERATION OF SAFEGUARDING ADULTS REVIEW REFERRALS BY THE BOARD

All referrals for a SAR will be considered by the SAR Subgroup/Panel which meets quarterly and more frequently when referrals have been received.

The SAR sub-group will consider all cases and present to the Board those it considers to meet the criteria for commissioning a SAR, using the template in Appendix 2.

The Board will make its decision through use where necessary of its voting rights.

The Board, must be as outlined in the LSAB Memorandum of Understanding, in order to make this decision.

The Independent Chair of the SAR subgroup will inform the referrer of the Board’s decision in writing.

Funding of each SAR will need to be agreed by the Board.

The Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- where there is an obvious and serious failing by one or more organisations;
- where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- where a death has occurred and there are concerns for others in the same household or other setting (such as a care home); or,
- deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.

If HM Coroner contacts the Board about any of these situations, the SAR Sub-Group will give careful consideration to recommending that a Safeguarding Adults Review be conducted. The Independent Chair will inform the Coroner of the outcome of these deliberations.
11. PROCEDURE FOR COMMISSIONING A SAFEGUARDING ADULTS REVIEW

When the Board decides that a SAR is necessary it must ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult.

The Board must ensure 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;
- Ways of working that promote an open, reflective learning culture.

The Board should agree Terms of Reference for any SAR they arrange/commission and these should be published and openly available.

When undertaking SARs the records should either be anonymised through redaction or consent should be sought.

The role of the SAR Subgroup/Panel in Safeguarding Adults Reviews

The Safeguarding Adults Review Sub-group will consider whether it should make the recommendations for the overall approach to a SAR or whether a specific Review Panel should be set up to do so. It may be that the Sub-group recommends some elements of the approach and asks the specific Review Panel to recommend others. Each case will be dealt with according to its needs. Either the Sub-group or the specific Review Panel will recommend:

- Which agencies should be asked to participate in the SAR;
- Whether the agencies concerned are required to secure their files;
- Which methodology should be used to facilitate learning in the case;
- The Terms of Reference for the SAR (including the time-span of the review);
- The required output from the SAR (e.g. a report);
- The timescales for completion of the SAR;
- Whether the Safeguarding Adults Review requires an Independent Facilitator or Chair, or if this role should be undertaken by a Board member agency;
- Whether an independent author is required and if so, whether this role should be undertaken by a Board member agency or someone entirely independent.
12. SAFEGUARDING ADULTS REVIEWS – METHODOLOGIES AND RECOMMENDATIONS

Methodologies
The Board recognises that there are many ways to achieve learning and that a proportionate response is required to aid that learning.

There are a number of methodologies that can be used to assist in unravelling learning from cases. When a SAR is required there are a number of methodologies that should be considered, each is valid in itself and no approach should be seen as more serious or holding more importance or value than another. All Safeguarding Adults Reviews conducted on behalf of the Board are of equitable significance and value. Research evaluating Adults safeguarding Serious Case Reviews in London notes, ‘Robust leadership is needed within and between all partner agencies, to enable cultures that embrace reflection, learning and change. Chief Officers, management boards, local politicians and Safeguarding Adults Boards all have a role to play in setting expectations and driving this agenda forward’. The Board supports this view.

Possible methodologies for Safeguarding Adults Reviews are set out below. This list is not exhaustive and the SAR Sub-group will use its collective experience and knowledge to recommend the most appropriate learning method of the case under consideration.

All of those participating in a Safeguarding Adults Review will be provided with training to support them in carrying out that role. Regardless of which methodology is used, contributing agencies need to be mindful that there may be public scrutiny of information provided by agencies to the Safeguarding Adults Review and, in particular, HM Coroner may request information. All agencies should, therefore, ensure that senior managers approve any written submissions to a Safeguarding Adults Review and where they consider it appropriate, seek legal advice prior to submission.

Significant Event Analysis
This approach brings together managers and / or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development. Significant Event Analysis or Audit has been used for many years in the NHS to analyse a significant event in ‘a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements’
A systems approach to conducting a Safeguarding Adults Review involves:

- Scoping of review / terms of reference: identification of key agencies/personnel; roles; timeframes:(completion, span of person’s history); specific areas of focus/exploration
- Appointment of facilitator and overview report author;
- Production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies;
- Material circulated to attendees of learning event; anticipated attendees to include: members from the Safeguarding Adults Partnership Board; frontline staff / line managers; agency report authors; other co-opted experts (where identified); facilitator and / or overview report author;
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt;
- Consolidation into an overview report, with: analysis of key issues, lessons learned and recommendations;
- Event to consider first draft of the overview report and action plan;
- Final overview report presented to the Board, agree dissemination of learning and monitoring of implementation;
- Follow up event to consider action plan recommendations;
- On-going monitoring via the Board.

**Using Individual Management Reviews (IMR) to Analyse Individual Agency Performance**

Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration, identifying good practice, and that where systems, processes, individual and group practice could be enhanced.

Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children’s Safeguarding Serious Case Review. A template for an Individual Management Review (IMR) and a checklist for a good IMR are available at Appendix 6.

Individual Management Reviews are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

**Multi-agency Combined Chronology**

Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a
combined chronology, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can use a combined chronology, with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.

Chronologies are important tools that are particularly useful when combined across agencies. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

*Traditional Serious Case Review, using a Combined Chronology, Individual Management Reviews and a Review Panel*

It may be that the sub-group considers that the best way to address a complex case is for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children’s safeguarding. This method will provide a detailed analysis of agencies’ work with an adult or group of adults and provide a familiar approach to learning.

*Recommendations to the Independent Chair of the Luton Safeguarding Adults Board (LSAB)*

In addition to recommending whether or not a review should take place following receipt of a referral, the Safeguarding Adults Review Sub-group will make recommendations to the Independent Chair of the LSAB about:

- Any urgent actions required by an agency or agencies that cannot wait until conclusion of a Safeguarding Adults Review;
- The overall approach to the Safeguarding Adults Review, where this has been delegated to a Review Panel, the Sub-group Chair will explain this to the Independent Chair.

13. **FINDINGS FROM SAFEGUARDING ADULTS REVIEWS**

The Board 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 Board decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation the Board receives from registered providers which is relevant to CQC’s regulatory functions will be given to the CQC on CQC’s request.
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;
- Contain findings of practical value to organisations and professionals.

The Chair of the Board will in conjunction with the DASS agree how the findings of
the SAR will be communicated to family and agencies involved as well as the
general public.

14. ROLES AND RESPONSIBILITIES

**Director of Adults Social Services**
The Director of Adult Social Services has the statutory role in relation to
safeguarding adults in the borough and therefore this post holder is ultimately
responsible for all Safeguarding Adults Reviews. The Independent Chair of the LSAB
and the Chair of the Safeguarding Adults Review Sub-group will ensure the Director
of Adult Social Services is advised of all Safeguarding Adults Review referrals and
decisions.

Where a Safeguarding Adults Review has a report of its findings, this will be
approved by the Director of Adult Social Services, together in consultation with the
Independent Chair of the LSAB and the Chair of the Safeguarding Adults Review
Sub-group. The Safeguarding Adults Board is ultimately responsible for approving
the report.

Where relevant, Luton Borough Council will be responsible for holding a joint LSAB
press statement / release as necessary on behalf of the Board. The Independent
Chair of the Board will agree this statement / release in consultation with the Director
of Adult Social Services and the Chair of the Safeguarding Adults Review Sub-
group. Senior responsible managers and Board members of any agencies who have
issues that are particularly sensitive within the report will also be involved in that
discussion. The Director of Adult Social Services will receive a recommendation from
the LSAB to accept the conclusion of a Safeguarding Adults Review, including the
content of any report and multi-agency action plan. The Director of Adult Social
Services will advise the Independent Board Chair of that acceptance.

The Director of Adult Social Services will meet with the Independent Chair of the
Board on an annual basis to consider the learning from all Safeguarding Adults
Reviews during that period.
**Independent Chair of the LSAB**
The Independent Chair of the LSAB is responsible for making a decision in response to the Safeguarding Adults Review Sub-group’s recommendations for a Safeguarding Adults Review and its associated methodology etc.

The Independent Chair of the LSAB is responsible for ensuring the Board receives regular updates in respect of progress of Safeguarding Adults Reviews.

The Independent Chair is responsible for ensuring the Director of Adult Social Services is briefed about all Safeguarding Adults Reviews, and where relevant, is advised of the content of all reports and action plans.

**Luton Safeguarding Adults Board (LSAB)**
Members of the LSAB will nominate senior appropriately experienced staff to participate in Safeguarding Adults Reviews in consultation with their agency’s senior responsible manager.

Members of the LSAB will consult regularly with those staff from their agency who are participating in Safeguarding Adults Reviews, to ensure they are informed but also can provide support and guidance. LSAB members should recognise that both these roles are exceptionally time-consuming and challenging and have a responsibility to ensure that their organisation provides these people with protected time and appropriate support to enable them to perform effectively in these roles.

LSAB members are responsible for ensuring their organisation’s actions within Safeguarding Adults Reviews multi-agency action plans are achieved.

**LSAB Safeguarding Adults Review Sub-group**
The Safeguarding Adults Review Sub-group is responsible for recommending to the Independent Chair of the LSAB whether a referral for a Safeguarding Adults Review meets the criteria. It is solely the Sub-group’s role to make this recommendation. This recommendation will clearly state the reasons for this recommendation. The Independent Chair will consider the information provided by the Safeguarding Adults Review Sub-group and decide whether or not to conduct a Safeguarding Adults Review.

Where a case is considered to meet those criteria, the Safeguarding Adults Review Sub-group will either make recommendations about the overall approach a Safeguarding Adults Review or delegate this role to the Review Panel.

The Safeguarding Adults Review Sub-group will recommend to the Independent Board Chair, where relevant, how the Adult at Risk, Person(s) and / or Organisation(s) Responsible and / or family members should be involved.
Where considered appropriate, a member of the Safeguarding Adults Review Sub-group will meet them at the start of the Safeguarding Adults Review to hear their views, explain the process and where appropriate, enable their perspective to be fed into the Safeguarding Adults Review.

The Safeguarding Adults Review Sub-group is responsible for performance managing the Safeguarding Adults Review process and reporting progress to the Board at each of its meetings.

The Safeguarding Adults Review Sub-group will nominate a member of the group, or appoint someone else considered appropriate to chair the Safeguarding Adults Review where required.

The Safeguarding Adults Review Sub-group is responsible for monitoring and recommending to the Board completion of Safeguarding Adults Review action plans.

**Safeguarding Adults Review Chair**

Where the Safeguarding Adults Review requires a chair, this will role will be undertaken by either a member of the Safeguarding Adults Review Sub-group, or another experienced individual who is nominated by the sub-group.

The Safeguarding Adults Review Chair will be responsible for achieving consensus of opinion about the key areas of learning and areas of change within the Review. The Chair will be accountable to the Safeguarding Adults Review Sub-group and will need to keep that person regularly informed of the progress of the Review in order that the Board is briefed.

The Safeguarding Adults Review Chair is responsible for helping those participating in a Safeguarding Adults Review to work together positively; providing appropriate challenge and focusing on good practice as well as areas of development and ensuring this is reflected in any accompanying report.

The Safeguarding Adults Review Chair is responsible for ensuring that all relevant interested parties are kept informed of progress of the Safeguarding Adults Review as appropriate.

The Safeguarding Adults Review Chair is responsible, together with the Chair of the Sub-group, for presenting Safeguarding Adults Review reports and action plans to the Independent Chair of the Board for consideration and recommendation to the Board.

**Independent Author**

Where an Independent Author is required in a Review, he/she will be appointed by the Independent Chair of the LSAB.
The Independent Author will work with members of the Safeguarding Adults Review to address each of the Terms of Reference of the Review and produce an Overview Report. This Report will have recommendations that are agreed by the Safeguarding Adults Review Panel. These will provide the Board with positive learning that will enable it to improve services and safeguarding in the Borough.

The Independent Author may communicate directly with the adult(s) at risk, person(s) or organisation(s), family members or significant others, with the permission of the chair of the Safeguarding Adults Review Sub-group / Panel.

**Safeguarding Adults Review Panel Members**

Members of a Safeguarding Adults Review panel will be nominated by their Board member and senior agency manager to work together in considering the issues within the Safeguarding Adults Review.

Safeguarding Adults Review Panel members will be senior managers without line management responsibility for the case and without previous involvement in the matter. However, they will be people with the ability and seniority to effect real change in their organisation and to influence others in the Review to effect change across the Partnership.

Where this role has been delegated by the Safeguarding Adults Review Sub-group, the Review Panel will recommend the detail of the approach to the review, including, timescales, terms of reference, methodology etc.

Members of the Safeguarding Adults Review Panel will feedback to their agency’s Board member on progress and key issues emerging from the Review.

**Adult(s) at Risk, Person(s) or Organisation(s) Alleged to Have Caused Harm, Family and Significant Others**

The adult(s) at risk, person(s) or organisation(s) alleged to have caused harm, family and other people close to the adult(s) at risk have a valuable role in the SAR process and the Board values the importance of their views and also recognises that the process can be difficult. As such, the Safeguarding Adults Review Sub-group will offer to meet with those individuals, as agreed appropriate as soon as the decision has been made to proceed with a Safeguarding Adults Review in order to hear their views and explain the process, highlighting the purpose of the Review and signposting them to other routes if they wish make a complaint.

Similarly it may be appropriate for the views of the adults at risk themselves, if possible and person(s) or organisation(s) alleged responsible to be fed into the Review.
The Safeguarding Adults Review Sub-group will keep all relevant individuals regularly informed of progress through the review.

At the conclusion of the Safeguarding Adults Review, once relevant reports and plans have been accepted by the Independent Board Chair, the Board and the Director of Adult Social Services, the Independent Chair of the Board and the Chair of the Safeguarding Adults Review Sub-group will offer to meet with these people to explain the Review conclusions.

15. GOVERNANCE

Safeguarding Adults Reviews are resource-intensive and can be highly sensitive for the individuals and organisations involved. It is vital that they are managed within a clear governance framework.

**Safeguarding Adults Review Sub-group**
The Safeguarding Adults Review Sub-group is accountable to the Board.

The Chair of the Safeguarding Adults Review Sub-group will ensure the Independent Chair of the Board and Director of Adult Social Services are informed of any referrals for Safeguarding Adults Reviews, significant developments and progress of reviews. An overview of each Safeguarding Adults Review will be reported to each meeting of the Board.

Action plans will be monitored by the Safeguarding Adults Review Sub-group. Any failure to complete actions will be escalated to the Independent Chair of the Board with the knowledge of the relevant SAB Board member. Where this relates to an organisation that is commissioned by the SAB member, this will also be raised with the commissioner and regulator.

**The Decision to Conduct a Safeguarding Adults Review**
All Safeguarding Adults Reviews will be conducted through the Safeguarding Adults Review Sub-group and only the Safeguarding Adults Review Sub-group, with representation from Adult Social Care, Police and Health can recommend a Safeguarding Adults Review.

The Safeguarding Adults Review Sub-group is responsible for making a recommendation to the Independent Chair of the Board and that individual will make a decision about whether or not to conduct a Safeguarding Adults Review.

The decision will be communicated to the referrer, the Board, the Safeguarding Adults Review Sub-group, the Care Quality Commission and NHS England, where the Review concerns any primary care organisations. The Director of Adult Social Services will also be informed of the decision.
**Safeguarding Adults Review Reports and Action Plans**

All reports of Safeguarding Adults Reviews are owned by the Board and held securely by the Luton Safeguarding Adults Team. Reports and action plans are only final when accepted by the Independent Board Chair and the Board and agreed by the Director of Adult Social Services.

Final Safeguarding Adults Review reports should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (this will be reflected in the recommendations and action plan);
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

When compiling and preparing to publish reports the Board will consider carefully how best to manage the impact of publication on Adult(s) at Risk, family members and others affected by the case. The Board comply with the Data Protection Act 1998 when compiling or publishing the report, and will comply also with any other restrictions on publication of information, such as court orders.

Individual Agency Management Reviews and Reports are owned by the agency that authored them.

The Board is responsible for recommending approval of all Safeguarding Adults Review Reports and Action Plans. The Safeguarding Adults Review Sub-group is responsible for monitoring and confirming completion of all Safeguarding Adults Review action plans.

All action plans will explicitly set out how agencies will evidence completion of an action and how the learning from the Safeguarding Adults Review will be embedded into practice.

When an action plan has been completed, this will be reported to the Board prior to closure of the Safeguarding Adults Review. The Review can only be closed when the Board is satisfied and has agreed that all actions have been completed.
Appendix 1
Safeguarding Adults Review Referral Form

The Luton SAB Safeguarding Adults Review Sub-group considers every referral on the basis of whether it meets the criteria for a Safeguarding Adults Review.

The Sub-group needs as much information as possible to enable members to make a proportionate decision as to how to respond to a case referral, ensuring, if the case is accepted for a review, that that maximum learning is achieved for the LSAB. Please complete as much information on this form as possible. If you have any questions, please do not hesitate to contact the Strategic Safeguarding Manager (adultsafeguarding@luton.gov.uk).

i. Referrer

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
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<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Agency (where applicable):</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone number:</td>
<td></td>
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<tr>
<td>Email address:</td>
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</tbody>
</table>

ii. Senior Manager Authorisation (where applicable)

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
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<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Telephone number:</td>
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</tbody>
</table>
iii. Adult at Risk and Person(s) Alleged Responsible to have Caused Harm or Neglect

<table>
<thead>
<tr>
<th>i. Adult at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Date of birth:</td>
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<tr>
<td>Date of death (where applicable):</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Health (physical):</td>
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<tr>
<td>Health (mental):</td>
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<tr>
<td>Agencies involved:</td>
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</table>

<table>
<thead>
<tr>
<th>ii. Person(s) or Organisation(s) Alleged Responsible to have Caused Harm or Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>Date of death (where applicable):</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Health (physical):</td>
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<tr>
<td>Health (mental):</td>
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</tbody>
</table>
### iv. Referral reason(s)

<table>
<thead>
<tr>
<th>How does this case meet the criteria for a Safeguarding Adults Review? (See Luton Safeguarding Adults Review Policy 2017/18 Please explain against each criterion).</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>What learning do you think can be achieved through review of this case?</th>
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<table>
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<tr>
<th>Which agencies / services are / were involved in this case?</th>
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<table>
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<tr>
<th>Which agencies / services should particularly achieve this learning?</th>
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<tr>
<th>What other learning / review processes have been followed? (please detail)</th>
</tr>
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</table>

<table>
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<tr>
<th>What did they achieve?</th>
</tr>
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<tbody>
<tr>
<td>(please detail)</td>
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</tr>
<tr>
<td>How has that learning been disseminated? (please detail)</td>
</tr>
<tr>
<td>What impact has it had? (please detail)</td>
</tr>
<tr>
<td>Please detail any other relevant information that will enable the Safeguarding Adults Review Sub-group of the Leeds SAB reach a decision about how to respond to this referral.</td>
</tr>
</tbody>
</table>
Appendix 2
Safeguarding Adults Review Subgroup Enquiry Form

Please complete this form and return to adultsafeguarding@luton.gov.uk

This information will be used to assist the SAR Subgroup in its decision making and recommendation to the Luton Safeguarding Adults Board.

<table>
<thead>
<tr>
<th>Referrer</th>
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<tbody>
<tr>
<td>Adult(s) at risk. Name: DOB: DOD: Address:</td>
<td></td>
</tr>
<tr>
<td>Person/organisation alleged to have caused harm: Name: DOB: Address:</td>
<td></td>
</tr>
<tr>
<td>Other relevant persons – family, friends: Name/s: Contact details:</td>
<td></td>
</tr>
<tr>
<td>Reason for referral:</td>
<td></td>
</tr>
</tbody>
</table>

Please answer the questions below and return completed form to: adultsafeguarding@luton.gov.uk
### Appendix 2

**Name of Agency:**

**Name of Person completing this form:**

**Job Title:**

**Contact Details:**

<table>
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<tr>
<th>Timeframe for consideration:</th>
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<tr>
<td>Did your agency have any contact with the adult?</td>
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<tr>
<td>Please give details.</td>
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</table>

<p>| Has your agency identified any safeguarding concerns in relation to or any other family member / significant other? (please detail) |
| Has your agency identified any areas of learning in the way in which services were provided to XXXX? |
| Has your agency undertaken any form of learning / incident review in relation to this case? (If so, please detail, including recommendations and actual / anticipated impact). |</p>
<table>
<thead>
<tr>
<th>Is your agency of the view that any form of multi-agency review should be undertaken? (Please explain your response)</th>
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<tbody>
<tr>
<td>Please detail any other information / comment that you consider would assist the sub-group in deciding how to respond to this referral</td>
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</table>
Appendix 3

Luton Safeguarding Adults Review Subgroup
Referral Recommendation and Decision

<table>
<thead>
<tr>
<th>Name of adult(s):</th>
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<tbody>
<tr>
<td>D.o.b.:</td>
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<td>D.o.d.:</td>
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<tr>
<td>Referral received from:</td>
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<td>Date referral received:</td>
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Please Summarise Reason for Referral:
<table>
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<th>Agencies who provided reports</th>
<th>Summary of reports</th>
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<tr>
<td>Learning Opportunities/options considered</td>
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SAR 2 Referral Decision Making Record

### Appendix 4

<table>
<thead>
<tr>
<th>Date Referral considered by subgroup</th>
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<tbody>
<tr>
<td>Recommendation and Reason</td>
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<tr>
<td>Chair of Meeting</td>
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<tr>
<td>Name</td>
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<td>Signature</td>
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<tr>
<td>Vice Chair of Meeting</td>
<td></td>
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<tr>
<td>Name</td>
<td></td>
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<tr>
<td>Signature</td>
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<td>Date when decision was made</td>
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APPENDIX 5

Chronology Template

Name of Agency:

Name, job title and contact details of person authorising submission of the chronology:

Date of submission:

Name(s) of Adult(s):

Dates to be covered by the chronology:

The agency does not have discretion as to what information should be included in the chronology. Please list all agency contacts related to the individual during the period required. Where there is no agency contact for periods during the timescale of the review, this should be made clear in the chronology. The information which is required under each heading is self-explanatory.

The chronology must be approved by a senior officer / manager prior to submission.

<table>
<thead>
<tr>
<th>Date</th>
<th>Contact with and by whom</th>
<th>Communication – within agency Specify: Meeting, letter, email, telephone call etc.</th>
<th>Communication – external to agency Specify: Meeting, letter, email, telephone call etc</th>
<th>Response</th>
<th>Wishes and feelings of adult</th>
<th>Source of evidence</th>
<th>Comments</th>
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Page 28 of 46
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<tr>
<th>Date</th>
<th>Contact with and by whom</th>
<th>Communication – within agency Specify: Meeting, letter, email, telephone call etc.</th>
<th>Communication – external to agency Specify: Meeting, Letter e mail, telephone call etc</th>
<th>Response</th>
<th>Wishes and feelings of adult</th>
<th>Source of evidence</th>
<th>Comments</th>
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Page 29 of 46
Appendix 6

Individual Management Review Guidance

1. Purpose

The aim of an Individual Management Review (IMR) is to:
• Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working
• Identify whether the case indicates that changes to practice could and should be made
• Identify how those changes will be brought about
• Identify examples of good practice within agencies

The exact issues to be addressed in each IMR will be identified by the terms of reference provided by the Review Panel.

2. Authors

Individual Management Review (IMR) authors will be individuals with expertise in writing objective, learning-focused reports. They will be nominated by their agency’s LSAB member and senior responsible manager. They will have had no previous, relevant involvement in the case.

In order to assist IMR authors in their role, they will be given the opportunity to attend a workshop to explain their role, the purpose of an IMR and to answer their questions.

IMR authors are responsible for their report, but the overall responsibility lies with the senior manager who authorises the IMR’s submission.

3. Process

i. Write the chronology

The chronology assembles the records of agency involvement into a simplified format, ordered by date. The information should be brief and should not go into personal detail. This will guide the process of interviews, and be merged with the chronologies of other agencies.

ii. Conduct a desk-based review

Before evaluating the agency’s involvement any further, the IMR author should assure him/herself that they are familiar with:
• The agency’s policies and procedures
• Any relevant partnership / multi-agency policies and protocols
• Professional standards and good practice
• National and local research and evidence-based practice

iii. Interview staff

The IMR author should then arrange to interview the staff members who had contact with the key individuals in the case. The interview should cover the staff member’s involvement, how they arrived at any decisions regarding the Adult(s) at Risk, Person(s) Alleged Responsible and other key individuals and whether the agency’s policies and procedures were followed.

The IMR author should be sensitive to the fact that the interview may be difficult for the staff member. The staff member may wish to be accompanied by an appropriate supporter.
A written record should be made of each interview and shared with the interviewee and any other people present.

iv. Disciplinary and complaint investigations
The overall Safeguarding Adults Review is not part of any disciplinary inquiry, but information that emerges in the course of an IMR may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. This is a matter for agencies to decide in accordance with their disciplinary procedures. The same consideration should be taken in relation to complaint procedures underway against any single agency.

v. Writing the IMR report and recommendations
The IMR author must then analyse the information gathered through the desk-based review and the interviews and produce a report and recommendations. A template for the report is provided in Appendix 7; see also the section on recommendations below.
NHS organisations may wish to feed their information into a single IMR author, who will produce a health overview report. This can follow the IMR template considered as part of the analysis and recommendations. Recommendations should be clearly directed to one or more parts of the health service. If the analysis indicates that policies and procedures have not been followed, relevant staff or managers should be re-interviewed to understand the reasons for this.

vi. Quality Assurance
The senior manager responsible for the Review within the agency should quality-assure the IMR report and recommendations and approve its submission.

vii. Feedback
When the report and recommendations are finalised, the senior manager should debrief the staff who have been involved in the Review. There should also be a second feedback session after the Safeguarding Adults Review has completed.

viii. Implementation of recommendations
The senior manager must then take forward the actions recommended as a result of the IMR. The IMR recommendations should be implemented immediately, and not wait for the conclusion of the overall Safeguarding Adults Review process.

ix. Confidentiality
IMR authors, Safeguarding Adults Review panel members and any others involved with the review process need to be clear that the information they learn about the case and agency’s involvement is confidential. This means it should not be discussed with anyone apart from key agency officers within the agency who are responsible for either the current case management, where information is required to manage the case, or the senior managers in the agency who need to be kept informed in order to achieve the agency’s approval.
It is vital that documents related to the Safeguarding Adults Review are stored in a locked cupboard with restricted access. Electronic documents must be password protected and access restricted.
4. Content
The minimum content is set out in the IMR template. Briefly, it comprises an introduction, a comprehensive chronology, analysis of the agency’s involvement, a conclusion and recommendations. However, the overall aim is to find existing good practice and points for improvement, which will ultimately serve to improve safeguarding adults in Luton.

An IMR should have the following features,
• The report is a comprehensive and well-structured management review of the agency’s full involvement with the key individuals in the Safeguarding Adults Review.
• The review takes full account of the outcomes for the Adult(s) at Risk and Person(s) Alleged Responsible concerned in light of their individual needs and their racial, cultural, linguistic and religious identity.
• Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.
• Good practice is highlighted with appropriate consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.

5. Recommendations
The recommendations are the result of the analysis of the agency’s involvement and seek to address any failings identified, or extend any good practice more widely.
Appendix 7

Individual Management Review Template

Individual Management Review report from (please insert agency name and logo)

STRICTLY CONFIDENTIAL

Safeguarding Adults Review: Insert agreed initials / reference

*Throughout the report please ensure that your report is fully anonymised including names, addresses, professional names and identifiable locations e.g. names of day centres, care homes with nursing, hospitals, health centres etc. Please provide an identifying key as a separate document*.

<table>
<thead>
<tr>
<th>Author: (please insert name and designation of report author here. State what your role is and how this equips you to undertake the review. State how you are independent of any operational involvement in the case)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed:</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Countersigned: (please insert name and designation of person signing off the report on behalf of the agency, this should be a senior manager)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed:</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

Version: xx (state ‘final’ when it is so)
2: Introduction
This individual Management Review report of (insert name of organisation here) is produced in accordance with Luton Safeguarding Adults Board’s procedure for conducting a Safeguarding Adults Review. The learning identified in this report will enable the Partnership to develop its adult safeguarding practice, systems and arrangements.

This report has been prepared following a review of the care/services provided to the [please insert name/s] Adult at Risk, the Person or Organisation(s) Alleged Responsible to have Caused Harm and their family, carers and significant others. Its purpose is to look openly and critically at the issues under consideration and consider whether or not, in hindsight, there were gaps in practice or the way in which single or inter-agency systems work and if so, to identify how those changes will be brought about.

i. About the organisation

Include here a brief description of your organisation and its role in relation to key individuals.
ii. Terms of reference

The terms of reference considered in undertaking this Safeguarding Adults Review have been agreed as:
Copy in terms of reference here

iii. Methodology

The following sources of information have been used to inform the review:
Insert the sources of information your agency has used, e.g. file reports, supervision records, training documents, policies and procedures, management information, interviews with staff (state job title only). Where unable to interview staff please state the reason for this.

iv. Detail of related reviews and processes

If any parallel reviews (i.e. untoward incidents, mental health review, disciplinary investigations [with no identifiable details] are on-going or completed but relevant, please make a note here.

3: Family and household composition

Insert a description of the Adult at Risk, Person(s) Alleged Responsible and other relevant family members and significant others. Use the genogram to support you (IMR. It is helpful to add this as an appendix). Please use the agreed initial or alternative names and state their relationship to each other. Highlight the people that your agency had contact with and briefly explain the nature of your agency’s involvement with them.

Section 3: Chronology of Service Provision and Involvement

You should already have assembled a comprehensive chronology that charts the involvement of the agency with the Adult(s) at Risk, the Person(s) Alleged Responsible and other significant individuals over the period of time set out in the review’s terms of reference. It should summarise the events that occurred, information known to the agency, the assessments and decisions reached; the services offered and provided and any other action taken.
This section of the report is the accompanying narrative and should draw on information contained in the chronology, bringing the chronology to life. From a review of your chronology highlight the significant episodes of involvement your agency had with the subjects of this review. Describe in more detail the reason for your agency’s involvement and what you actually did. Episodes of service provision may be broken down as appropriate e.g. by periods of the case being ‘open’ with your agency, by change of keyworker and so on.
Section 4: Analysis of involvement
The analysis should consider the events that occurred, the decisions made and the actions taken or not taken; consider not only what happened but why. Assess actual practice against policies, guidance and legislation.
The following are examples of the areas that will need to be considered for all reviews:

Service and practitioner standards:
• Was the agency’s involvement in line with organisational expectation of services and/or national expectation of this service?
• Were practitioners sensitive to the needs of the Adult(s) at Risk or the Person(s) Alleged Responsible? Were they knowledgeable about potential risks of abuse or neglect? Were they aware of what to do if they had concerns? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
• Was the level of staff supervision appropriate and did it address the issues for this case?
• Were senior managers involved at the appropriate points?
• Please highlight good practice as well as that which in hindsight could have been improved

Policies, procedures and risk assessment:
• Did the agency have policies and procedures in place for dealing with safeguarding concerns? Were these procedures and policies effective, and agreed by practitioners to be effective and worth using?
• Did the agency have policies and procedures for risk assessment and risk management? Were these assessments correctly used in this case?
• What assessments were undertaken by the agency? Were any opportunities to undertake assessments missed? Do assessments and decisions appear to have been reached in an informed professional way?
• Was any threshold applied for accessing the service appropriate and in line with agency thresholds?
• Did actions or risk management plans accord with assessments and decisions made? Were appropriate services then offered or provided?
• Were appropriate statutory actions taken in line with the relevant time frames (reviews, re-assessments, visits)?

Person-centred focus:
• When and in what way were the client’s wishes and feelings ascertained and considered? Were they given enough information, options and time to make informed decisions?

Was the client signposted or referred to other agencies that they might prefer to work with?
• Was the practice sensitive to the age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status of the people concerned? Was any disability or vulnerability considered and responded to appropriately?
• Were services accessible?

Inter-agency working:
• Did the agency comply with working protocols agreed with other agencies, including any information-sharing protocols?
• What evidence was there of good inter-agency activity?
• Did anything adversely affect the inter-agency activity?

Good practice:
• Are there ways of working effectively that could be passed on to other organisations or individuals?
• What evidence was there of good inter-agency activity?
• Was any additional support or service provided above what would normally be offered? Were there any examples of good practice over and above that which would be routinely provided?

Lessons to be learned:
• Are there lessons to be learned from this case relating to the way in which this agency works to safeguard adults at risk of abuse or neglect? Where can practice be improved?
• Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
• If you have highlighted areas of work that were not of the required standard, please consider, what contributed to services being below expectations – individual workers’ situations, the organisational structure culture or the political context?
• Did anything or anyone appear to interrupt the decision making process?
• Did anything adversely affect inter-agency activity?
• Have any previous Safeguarding Adults Reviews made recommendations about similar concerns and why weren’t the lessons embedded from these previous reviews?

Terms of reference
In addition to the questions above, address any specific issues in the terms of reference.

Section 5: Conclusions
Pull together the findings and analysis in order to comment on:
• Service provided, quality of practice and adherence to procedures
• Appropriateness of policies, procedures, guidance, training and supervision
• Decision making
• Action taken in respect of decisions made
• Resource implications, where this is directly relevant

Section 6: Recommendations
Individual agency recommendations for action contained in the report will be considered by the Review Panel for inclusion in the Overview Report. The Review Panel may also recommend further actions for your agency to be included in the overview report.
Any individual agency recommendations not included in the Overview Report are expected to be acted on within individual agency governance arrangements

Recommendations for action must flow from your conclusions. Recommendations can include changes for your agency procedure, practice, or deployment of resources. In
addition you may make recommendations that may have an impact on other agencies as well as your own. Any recommendation that suggests immediate action is required should be reported to your Senior Manager and the Chair of the Review Panel and should not wait until the completion of the report.

Section 7: Feedback
Please identify how your agency intends to:

1. Feedback the conclusions of the IMR to staff
2. Communicate and disseminate lessons learned from the Safeguarding Adults Review, when it has concluded
## Individual Management Review Checklist

<table>
<thead>
<tr>
<th></th>
<th>The agency identified a suitably independent author to complete the IMR and this is clearly stated in the IMR</th>
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<tbody>
<tr>
<td>2</td>
<td>The IMR author has provided an overview of the role of the agency.</td>
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<tr>
<td>3</td>
<td>The IMR author has provided a brief summary of their background and suitability to complete this IMR.</td>
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<tr>
<td>4</td>
<td>The IMR follows the template provided by Luton SAB and is fully anonymised using the codes provided. Professionals are identified by their job title and a list provided as a separate appendix.</td>
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<tr>
<td>5</td>
<td>The Terms of Reference are clearly set out and each Term of Reference answered if applicable to the agency.</td>
</tr>
<tr>
<td>6</td>
<td>The IMR sets out which records were accessed.</td>
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<tr>
<td>7</td>
<td>All relevant staff have been interviewed and where this has not been possible this has been fully explained in the IMR</td>
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<tr>
<td>8</td>
<td>The IMR has retained a focus on the people concerned and the Adult at Risk’s voice comes through in the IMR.</td>
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<tr>
<td>9</td>
<td>The IMR has addressed issues of race, culture, language, religion and disability.</td>
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<tr>
<td>10</td>
<td>The IMR is balanced, well-structured, comprehensive, and analytical and looks openly and critically at practice, decisions made, and services Adult(s) at Risk, The Person(s) Alleged Responsible, family members and other significant individuals. Good practice is identified.</td>
</tr>
<tr>
<td>11</td>
<td>The IMR reaches well-founded conclusions and identifies the key lessons to be learnt.</td>
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<tr>
<td>12</td>
<td>The recommendations flow from the lessons learnt and are SMART (specific, measurable, achievable, realistic and timely). There are recommendations on how to evaluate the impact and review the implementation of change.</td>
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<tr>
<td>13</td>
<td>The IMR has been signed off by a Senior Manager in the agency</td>
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<td>14</td>
<td>There is a clear plan of how the findings will be fed back to the staff members involved.</td>
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Appendix 8

FAMILY COMPOSITION/GENOGRAM
SUBJECT:

Name: 
D.O.B: 
D.O.D: 
Address: 

FAMILY COMPOSITION
Family member (name): 
Date of Birth: 
Address: 

Family member (name): 
Date Of Birth: 
Address: 

Family member (name): 
Date of Birth: 
Address: 

Family member (name): 
Date of Birth: 
Address: 

Other addresses on file: 
Other household members/significant others: 
Name: 
Date of Birth: 
Name: 
Date of Birth: 

PLEASE INSERT GENOGRAM WITH INFORMATION KNOWN TO YOU AGENCY
Appendix 10

Safeguarding Review – Action Plan

Review Identifier:
Date(s) approved by LSAB and Director of Adult Social Services:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Relevant agencies</th>
<th>Action(s)</th>
<th>Deadline</th>
<th>Evidence of compliance to be provided</th>
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### Appendix 11

**Safeguarding Adults Review – Action Plan Governance**

**Case Review Identifier:**

**Agency:**

**Date:**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Is the recommendation being met? (Compliant / partially complaint / not compliant)</th>
<th>What evidence do you have that practice is or is not consistent with the recommendation?</th>
<th>What work is in place or planned to support the organisation to implement this recommendation?</th>
<th>Evidence of compliance</th>
<th>RAG rating (for completion by SAR Subgroup)</th>
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