North Lincolnshire Safeguarding Adults Board

Safeguarding Adults Review Framework

Document control

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May 2022	Final	Version approved.
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Contents

1. Legal and Policy Context

The Care Act 2014 came into force in April 2015 and created a new legal framework for Adult Safeguarding. Section 44 of the Act requires Safeguarding Adults Boards (SAB) to undertake a Safeguarding Adult Review (SAR) in specific circumstances and places a duty on all Board Members to contribute to undertaking reviews, sharing information, and applying the lessons learnt. The law requires SABs to arrange a safeguarding adult review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the person at risk. The SAB must also arrange a safeguarding adult review when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

However, the Care Act 2014 also enables SABs to carry out reviews in other situations where it feels this would be appropriate to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be situations that provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, but which may not meet criteria for a Safeguarding Adult Review. 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.

This framework reflects and builds on the six safeguarding principles outlined within the Care Act 2014. These should be the basis upon which judgements are made about events and practice and are also the principles underpinning the review of the process itself. These principles are:

Empowerment	Presumption of person led decisions and informed consent.
Prevention	It is better to take action before harm occurs.
Proportionality	Proportionate and least intrusive responses appropriate to risk.
Protection	Support and representation for those in greatest need.

Partnership Local solutions through services working with their communities.

Accountability Accountability and transparency in delivering safeguarding.

2. Roles and Responsibilities

The SAB is supported by the SAR Executive Group in the implementation, management, and oversight of the Safeguarding Adults Review Framework. The SAR Executive Group is responsible for making recommendations to the Independent Chair as to whether a review should take place and the most appropriate type of methodology. The group will also oversee the publication of the Executive SAR report / summary. The Independent Chair will make a decision on behalf of the SAB as to whether to agree the recommendation made by the SAR Executive Group. The Protection and Accountability Subgroup will oversee the review process and the development of the action plan.

The SAR Executive Group is responsible for

a) Gathering the appropriate information necessary to make a recommendation to the Independent Chair of the SAB on whether the criteria are met, and which methodology would be appropriate to use.

b) Oversight of the implementation of any multi-agency action plans arising from reviews and for ensuring that the impact of changes on the experiences and outcomes for people with care and support needs are evaluated.

c) Monitoring and ensuring implications for the Board's existing Policy and Procedures are amended if appropriate to reflect the learning lessons.

The SAB has access to the National SAR library which contains links to national and local SARs, reports, and inquiries (both historic and current) and aims to support to dissemination of the learning arising from these across North Lincolnshire and in doing so promote evidence-based practice. All the entries on the national SAR library database include a summary and professional learning points. nationalnetwork.org.uk/search.html

3. Purpose

The purpose of a Safeguarding Adult Review is to:

- Determine what might have been done differently that could have prevented harm or death.
- Identify lessons and apply these to future situations to prevent similar harm occurring again.
- Review the effectiveness of multi-agency safeguarding arrangements and procedures.
- Inform and improve future practice and partnership working.
- Improve practice by acting on learning - developing best practice.
- Highlight any good practice identified.

A SAR is not an inquiry into how an adult died or suffered any injury or who is culpable. It is not a re-investigation of the case, and 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, Social Work England (formerly 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, the reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. Agencies may also have their own mechanisms for reflective practice. This SAR protocol is not intended to duplicate or replace these. Such review/investigation procedures and /or reflective practice can be used alongside and to contribute to a SAR and something which an agency may wish to consider as an alternative option for reviewing a case should a request for a SAR be deemed not to meet the criteria.

4. Criteria for a Safeguarding Adult Review

The Care Act 2014 advises that the Local Safeguarding Adults Board is the only body which can commission a Safeguarding Adult Review in its area. The SAB must arrange a SAR of an adult in its area with needs for care and support (whether or not the local authority was meeting those needs) if:

1) The situation involves an adult with care and support needs (whether or not the local authority was meeting those needs).

2) There is reasonable cause for concern about how the SAB, its members or organisations worked together to protect the adult.

AND

3) The person died and the SAB knows / suspects this resulted from abuse or neglect whether known or suspected and there is concern partner agencies could have worked more effectively to protect the adult.

OR

4) The person has not died but the SAB knows or suspects that they have experienced serious abuse / neglect.

5) SABs are free to arrange a SAR in any other situation involving an adult in its area with needs for care and support.

5. Requests for a Safeguarding Adults Review

Some situations referred may overlap with other statutory review processes such as a Domestic Homicide Review, Mental Health Homicide Independent Investigations, Multi Agency Public Protection Arrangements (MAPPA) or a child Serious Case Review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how interfaces between these should be managed, to dovetail activity as far as possible.

There may also be parallel processes in place such as a criminal investigation or coroner's inquest, which whilst not preventing a request, will need to be taken account of in terms of the timing and management and publication of any SAR.

Early consideration should be given to the involvement of the adult and their family and friends, and should the case meet the criteria for a Safeguarding Adults Review, the involvement of the adult and their family friends should be an integral element of the review.

If it is felt that the circumstances of the case may benefit from a SAR, the agency's SAB representative must be briefed on the situation and notified of the intention to make a request.

It is expected that any request is discussed and agreed with the agency safeguarding lead prior to submission.

The request document (appendix 1) should be submitted once the SAR criteria appear to be met. The author of the request should provide all relevant information. It is

important to note all the agencies that are known to be involved in the case. This will enable further information to be sought effectively.

Completed SAR requests should be sent to the SAB Business Team email at:

SafeguardingAdultsBoard@northlincs.gov.uk

6. Screening the request

On receipt of a SAR request the SAB Business Unit will send confirmation of its receipt to the author of the request and inform the SAR Executive Group. The SAB Business Unit will screen the request to make sure all sections are properly completed and contact the author of the request if any further information is required, and to ensure that the incident took place within the North Lincolnshire SAB area.

The document for requesting an overview of agencies involvement, guidance, and letter (appendix 2) will be sent to relevant agencies for return within four weeks of receipt. For SAB member agencies, it will be sent to the Board Member and copied to the agency safeguarding lead. The document will be sent to a senior manager within other agencies. Any agency not familiar with the process will be contacted by phone to discuss the SAR process and requirements. Agencies must ensure that officers completing the scoping document are clear about the expectations. Clarification can be sought from the SAB Business Unit if required. The overview of agency involvement must be submitted by the specified date.

Timescale – 4 weeks

7. Recommendations and decision making

The overview of agency involvement documents must be returned to the SAB Business Unit by the specified date. Information is collated and an overview report of the circumstances compiled by the SAB Business Unit, this will be distributed to the SAR Executive Group for review 2 weeks prior to the SAR Executive Group meeting to enable members' time to review all scoping documents. The SAR Executive Group will collectively consider whether the author of the request should also be invited to the meeting.

The SAR Executive Group will discuss the request and agency overview information. For the meeting to be quorate there must be in attendance representatives from the three-statutory agencies (North Lincolnshire Council, North Lincolnshire Health and Care Partnership, Humberside Police). The views of the adult and/or family and friends

must be shared if known. The SAR Executive Group will consider whether the S44 criteria are met.

If the SAR Executive Group do not recommend a SAR, they will clearly record why they believe the S44 criteria is not met.

If the view of the SAR Executive Group is that the S44 criteria are met, consideration will be given to which methodology would be proportionate to the circumstances and effectively identify the relevant learning. The SAR Executive Group will agree the key themes.

8. Safeguarding Adults Review Methodologies

There is no set process to undertaking SARs. The methodology should be determined according to the specific circumstances of each case, recognising that no one model will be applicable for all cases. Therefore, the SAR Executive Group will need to weigh up what type of 'review' process is proportionate to the complexity of the case and will promote effective learning and improvement action. Resource implications should be considered, although they should not be the determining factor.

The following table should be used as a guide when determining which methodology may be appropriate to use.

Level	Application	Suggested methodology	Completed by
Concise investigation	Suited to less complex cases, which can be managed by a single agency or small group	B C	B (Peer Review) • Peers can be identified from constitute professionals/agencies from the NLSAB. • Peers could be sourced from another area or SAB. C (Significant Event Analysis) • Multi-Agency approach • Led by a member of NLSAB who is independent from the case
Comprehensive investigation	Suited to more complex cases which require a multi-agency review	B,	B (Peer Review) • Peers can be identified from constitute professionals/agencies from the NLSAB. • Peers could be sourced from another area or SAB.

		C, D	C (Significant Event Analysis) • Multi-Agency approach • Led by a member of NLSAB who is independent from the case. D (Multi-Agency Combined Chronology) • Multi-Agency approach • Led by a member of NLSAB who is independent from the case
Independent investigation	This model is used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working. When the integrity of the investigation is likely to be challenged; Where it will be difficult for an organisation(s) to conduct an objective investigation. Or due to the large number of organisations involved in the case.	A	A (Multi-Agency Learning Lessons Review) • Appointment of a panel, including a Chair (who must be independent of the case) • Expert membership may be required. • Appointment of an independent report author to write the review report (there can be a joint Chair/author)

Methodologies to Support Safeguarding Adults Reviews.

Each of the methodologies are valid in itself, and no approach should be seen as more serious or holding more importance than another. The SAR Executive Group will make a recommendation on the methodology to the NLSAB Independent Chair.

A. Multi-Agency Learning Lessons Review

B. Peer Review Approach

C. Significant Event Analysis

D. Multi-agency combined chronology

A. Multi-Agency Learning Lessons Review

This model is used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working; when the integrity of the investigation is likely to be challenged; where it will be difficult for an organisation(s) to conduct an objective investigation; or due to the large number of agencies involved in the case.

This model includes:

- The appointment of panel, including a Chair (who must be independent of the case). Expert membership may be required. The panel determines terms of reference and oversees process.
- Appointment of an Independent Report Author to write the overview report and summary report. There can be a joint Chair / Author.
- Agencies undertaking chronologies and Individual Management Reviews outlining their involvement, key issues, and learning.
- Production of a report and recommended actions.
- Formal reporting to NLSAB.
- Recommendations are implemented and monitored across partnerships and reporting to NLSAB.

B. Peer Review approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which are used increasingly within Adult Social Care.

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

There are two main models for peer review:

- Peers can be identified from constitute professionals/agencies from NLSAB members, or.
- Peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

C. Significant Event Analysis

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. This approach should be led by an appropriate LSAB Member who is independent from the case.

This model includes:

- Information gathering – collation of as much factual information about the event as possible from a range of sources.
- Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment.
- Analysis of the Significant Event: The key questions that require answering in a Significant Event Analysis or Audit are I. How could things have been different? ii. What can be learned from what happened? iii. What has been learned? iv. What has been changed or actioned?

D – 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 using a Chronolator tool. This enables a group of agencies to identify strengths and 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 multiagency review panel. This approach can be led by an LSAB member who is independent from the case.

The SAR Executive Group Chair will advise the NLSAB Independent Chair in writing as to the recommendation of the SAR Executive Group. The Independent Chair will then make a decision on behalf of SAB as to whether to agree the recommendation(s) of the SAR Executive Group. The NLSAB Independent Chair may seek further information as required.

In some cases, the SAR Executive Group may make a provisional recommendation pending further information. For example, where there is an ongoing criminal investigation which may be compromised by the SAR process taking place.

Timescale – within 1 week of the SAB Executive Group Meeting taking place.

9. Coroners

Any SAR may need to take account of a Coroner 's inquiry, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay. Coroners are independent judicial officer holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are 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).

- Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries/actions are identified by the coroner or their officers. In the above situations the local SAB should give serious consideration to instigating a SAR.

10. Considerations for Safeguarding Adults Review Chair / Author

The following should be taken into consideration when commissioning/allocating the author of a Safeguarding Adults Review. It is acknowledged that each SAR will be different in circumstances and therefore this guidance should be used flexibly in line with the SAR requirements.

Experience

- Experience in the field of safeguarding adults or other field related to the specific SAR, including experience at a managerial or senior level.
- Partnership working in a range of sectors, statutory, voluntary, and independent.

- Investigative review experience and understanding of how quality assurance has resulted in the delivery of effective practice and improved outcomes.
- Handling complex group dynamics, including chairing and group facilitation.
- Report writing experience which demonstrates:
  i. an understanding of language and style for the audience.
  ii. a robust analysis.
  iii. that the original scope and terms of reference are addressed.

Knowledge

- Legislation, guidance, research and good practice in safeguarding adults and Mental Capacity.
- Knowledge of systems methodology.

Skills

- Strong leadership and ability to motivate others.
- Strong communication and engagement skills, able to draw from people the rationale for decisions made in relation to the issues faced.
- Non-judgmental with a high level of interpersonal skills.
- Demonstrable facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
- Collaborative problem-solving experience and enthusiasm for participative approaches.
- Good analytic skills and ability to manage qualitative data.
- Inclined to promote an open, reflective learning culture aimed at improving future practice.
- Resilient and able to handle challenge appropriately at a senior manager / executive level.
- Open mindedness and professional curiosity.
- Creative thinking for sharing lessons to maximise learning opportunities.
- Where appropriate any other specialist skills identified in relation to the circumstances of the case.
- Ability to work with families.
- Non blame approach.
- Time management – ability to meet deadlines.
- Experienced in investigation techniques / knowledge/ experience of different methodologies including root cause analysis.
- Cultural awareness.

11. Involving adults and / or their representatives in Safeguarding Adult Reviews

It is important to recognise that each SAR will be unique, and it is therefore important that careful consideration is given to the best way of notifying and involving the adult, family, and friends.

The following sets out a set of principles based on good practice regionally and nationally that Safeguarding Adult Boards should consider when involving families as part of the SAR process.

- The involvement should be clearly documented in the Terms of Reference for the SAR.
- It would be expected that the SAR Chair / Author is the lead liaison with the family for matters concerning the review process.
- If a decision is taken to not involve the adult at risk and/or their families, the reasons should be informed by legal advice and clearly documented.

Early notification should take place with the adult at risk and family/friends to agree how they wish to be involved and how they should be supported. Where appropriate, as a Care Act 2014 requirement, an independent advocate to represent and support the adult through a SAR will be sourced/arranged.

It will be a very sensitive time for everyone, and consideration should be given at an early stage to the following:

  - How notification will be done, and by whom – usually this will be the SAR Chair / Author.
  - The ongoing identified support to those involved (how and who will provide it).
  - Informing the adult and / or their representative about how the process works and what role they will have in shaping this.
  - How they want to be involved.
  - The purpose, process, and parameters of the SAR, which should be communicated in the most appropriate setting and method to ensure that these can be understood and convey respect to those involved.

The timing of such notifications is crucial particularly where there are ongoing police investigations. This decision should be considered by the SAR Executive Group with the Police member present.

Involving the adult and / or their representative can range from formal notification only, to inviting them to share their views with the SAR Chair / Author in writing or through a meeting/interview.

Updates must be given to the adult and / or their representatives at key stages of the review and before publication of the report.

The adult and / or their representative should be given the opportunity to feedback on the report before it is completed (this may not result in significant changes).

If felt appropriate the Board may wish to provide the adult and / or their representative an update on progress against the action plan in agreed intervals.

12. SAR Process

SAR Request

- Request (appendix 1) is emailed securely to: SafeguardingAdultsBoard@northlincs.gov.uk
- Confirmation of receipt is sent to the author of the request.
- The SAB Business Team will screen the request to ensure the form has been completed correctly and that the incident took place within NLSAB area.
- The SAR Executive Group will identify if initial criteria are met.
- If the SAR Executive Group believe it is clear the criteria are not met, they will write to the Independent Chair and advise of their recommendation not to conduct a SAR.
- If the Independent Chair is in agreement a SAR will not be completed the SAB Business Team will feed back to the author of the request.

Agency overview process

- The SAB Business Team will make contact via telephone contact with agencies not familiar with the process.
- The SAB Business Team will send agency overview template and letter (appendix 2) and advise of return date.
- The SAB Business Team will inform the author of the request that further information is being sought from partner agencies.

Agency overview templates returned.

- All agency overview documents are collated by the SAB Business Team and sent securely to the SAR Executive Group – 2 weeks prior to a SAR Executive Group meeting being arranged.

SAR Executive Group meets.

- SAR Executive Group Meets to determine if a SAR is required, and if so which methodology. The identified methodology should be appropriate and proportionate to the case under review.
- SAR Executive Group Chair writes to the Independent Chair.
- NLSAB Independent Chair confirms their decision made to the SAR Executive Group Chair.

- The SAB Business Team will notify the author of the request as to the decision made.

If an Independent Author or an independently chaired Learning Lessons Review Panel is required, the SAB Independent Chair will be responsible for commissioning someone suitable to undertake the review. It is important to note that it is not a requirement of the Care Act that all SARs are conducted by external Independent Reviewers. SARs can be led by individuals who are independent from the case in those organisations whose actions are being reviewed.

Appendix 1

Request for a Safeguarding Adults Review

North Lincolnshire Safeguarding Adults Board

Request Form for a Safeguarding Adults Review

The following considerations should be made when deciding whether to make a referral for a Safeguarding Adults Review:

1. The situation involves an adult with care and support needs (whether or not the local authority was meeting those needs).
2. There is reasonable cause for concern about how the SAB, its members or organisations worked together to protect the adult.

AND

3. The person died and the SAB knows/suspects these results from abuse or neglect whether known or suspected and there is concern partner agencies could have worked more effectively to protect the adult.

OR

4. The person has not died but the SAB knows or suspects that they have experienced serious abuse/neglect.

Please note that submissions will be considered with the prompt sheet being completed.

PROMPTS TO HELP DECIDE IF A REQUEST SHOULD BE CONSIDERED FOR SAFEGUARDING ADULT REVIEW

Question or consideration	Yes/No	Any comments or notes
Has a service user died?		
Have you given full consideration to criteria set out under Section 44 of the Care Act 2014 (for ease of reference they are set out on the referral form)		
Is there clear evidence of significant risk or harm that was not recognised by organisations or individuals in contact with the adult at risk or the perpetrator?		
Is there clear evidence of significant risk or harm that was not shared with others?		
Is there clear evidence of significant risk or harm that was not acted on appropriately?		
Did a family member cause the serious injury or death?		

Was the adult at risk abused in an institutional setting?		
Do one or more agencies consider that its concerns were not taken sufficiently seriously or acted upon appropriately by another agency?		
Was the adult at risk subject to a safeguarding plan or of a previous safeguarding adult S42 Enquiry?		
Does the case have implications for a range of agencies and/or professionals?		
Does the case suggest that the SAB may need to change its protocols or procedures, or that policy and procedures are not being properly used, understood, or acted upon?		

REQUEST NOTICE

REQUEST INFORMATION	
Name (of person making a request):	
Name of your agency	
Position:	
Your email:	
Your address:	
Your telephone number:	

IDENTIFYING INFORMATION	
Name of person(s) being referred:	
Date of Birth(s)	
Date of incident or issues (please give time range if more appropriate)	

SUBMISSION DETAILS	
Email to **SafeguardingAdultsBoard@northlincs.gov.uk** **Tel: 01724 297000**	**By post to:** **Safeguarding Adults Board** **Church Square House** **30-40 High Street** **Scunthorpe** **North Lincolnshire** **DN15 6NL**

REASON FOR REQUEST **(Do not exceed 3 sides of text)**
Why are you requesting a Safeguarding Adult Review? In making your request, you should consult the local policy, specifically stating which criteria is met and how. The criteria you should consider are: 1) The situation involves an adult with care and support needs (whether or not the local authority was meeting those needs). 2) There is reasonable cause for concern about how the SAB, it's members or organisations worked together to protect the adult. AND 3) The person died and the SAB knows / suspects this resulted from abuse or neglect whether known or suspected and there is a concern partner agency could have worked more effectively to protect the adult. OR 4) The person has not died but the SAB knows or suspects they have experienced serious abuse / neglect. 5) SABs are free to arrange a SAR in any other situation involving an adult in its area with needs for care and support.

Please include details of any previous safeguarding involvement, and names of professionals involved in the case.	
[insert your summary here]	
Completed by	
Signed	
Name (please print)	
Date	

For completion by the SAB Manager

	Decision	**Date**
Recommendation of the SAR Executive Group		
Decision of the SAB Independent Chair if appropriate		

Appendix 2

Template letter and request for overview of agency involvement and brief chronology

Dear XXXXX

Regarding: Request for overview of agency involvement and brief chronology

In accordance with the Care Act (2014) the North Lincolnshire Safeguarding Adults Board is considering whether or not to undertake a Safeguarding Adults Review in relation to -

Adult at Risk:

Date of birth:

Address:

Time period:

The purpose of a review would be to determine whether relevant agencies and individuals involved in the case might have done anything differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

We are asking you to confirm whether or not the person(s) (named above) was known to your services, and if so, for you to review your records and to provide a brief chronology and overview of involvement and any other relevant information that might help to inform our decision.

We would be grateful if you would arrange for the attached template to be completed and returned to SafeguardingAdultsBoard@northlincs.gov.uk by (date xx.xx.xxxx)

Any information shared will be considered by the SAR Executive Group who will then make recommendation as to whether a Safeguarding Adults Review is required.

If you need further clarification or advice in relation to completing the template, please do not hesitate to contact the Safeguarding Adults Board Business Unit - SafeguardingAdultsBoard@northlincs.gov.uk

Yours sincerely

SAR Executive Group Chair

Chronology and overview of involvement (To be completed by the organisation)

Name of organisation submitting report:

Name of report author:

Contact telephone number:

Email:

Within the specified time period:

Following your organisations initial review of available information-

1. Did your organisation have contact with the person at risk? (Y/N)

2. Did your organisation have any duty of care or responsibility for the person at risk? (Y/N)

3. Did your organisation have contact with the service of concern? (Y/N)

4. Did your organisation have any responsibility in relation to the service of concern? (Y/N)

If yes to any of these, please provide a brief chronology (Below) of relevant events, and contacts, including correspondence and telephone calls

Give a brief overview of your agency's involvement

Chronology of relevant events, and contacts		
Date	**Description of event or contact**	**Source of information**

Other relevant information.

Please give any other relevant information from your initial review that might help to inform the decision as to whether or not a Safeguarding Adults Review is required.

This might include e.g.

- whether services met expected professional standards?
- any safeguarding issues and how they were responded to?
- whether safeguarding and other policies and procedures appear to have been followed?
- potential to share good practice or learning with other agencies?
- any actions plan you have put in place as a result of your initial review?

On completion, please send this form to North Lincolnshire Safeguarding Adults Board

SafeguardingAdultsBoard@northlincs.gov.uk