

GATESHEAD SAFEGUARDING ADULTS BOARD

# **Practice Guidance Note 1 Safeguarding Adults Review**

## **Practice Guidance Summary**

This practice guidance note forms part of a series of documents that is intended to be used by senior managers and practitioners when dealing with issues pertaining to Adult Safeguarding. They support the overarching Gateshead Safeguarding Adults Board Policy and Practice Guidance

# Contents

	Page
<b>Section 1: Policy</b> .....	<b>3</b>
1.1 Introduction .....	3
1.2. Practice Guidance Background.....	4
1.3 Purpose of Safeguarding Adults Review.....	4
<b>Section 2: Operational Procedure</b> .....	<b>6</b>
2.1 When to undertake a Safeguarding Adults Review.....	6
2.2 Initiating a Safeguarding Adults Review .....	7
2.3 Conducting a Safeguarding Adults Review .....	7
<b>Section 3: Quality Assurance</b> .....	<b>10</b>
3.1 Governance and Accountability.....	10
3.2 Performance Monitoring.....	10
3.3 Practice Guidance Review .....	10
<b>Appendix A</b> – Individual Management Reviews.....	<b>11</b>
<b>Appendix B</b> – Overview Report by Safeguarding Adults Review Panel Chair .....	<b>13</b>
<b>Appendix C</b> – Gateshead Safeguarding Adults Review Referral.....	<b>14</b>
<b>Appendix D</b> – Safeguarding Adults Review Timescales.....	<b>17</b>

# Section I: Policy

## I.1 Introduction

I.1.1 The purpose of this Protocol is:

- To ensure that the Gateshead Safeguarding Adults Board (SAB) is able to undertake any required Safeguarding Adults Reviews in accordance with its obligations under section 44 of the Care Act 2014;
- To ensure that local practice is in line with the Care and Support Statutory Guidance issued by the government;
- To safeguard and promote individual well-being by working to further protect adults from abuse and neglect;
- To facilitate a consistent approach to the process and practice in undertaking a Safeguarding Adults Review (SAR)
- To provide guidance to the SAB, the relevant supporting SAB sub-group and any convened Safeguarding Adults Review Panels.

I.1.2 Chapter 14 of the Care and Support Statutory Guidance issued in relation to the Care Act 2014 replaces the 'No Secrets' guidance previously issued by The Department of Health and Home Office.

I.1.3 The Care Act 2014, which will come/come into force in April 2015, imposes a duty on local authorities to establish a SAB. Section 44 of the Act obligates such Boards to make, in certain circumstances, the arrangements necessary to undertake a SAR.

I.1.4 Section 42 (1) of the Care Act 2014 states that the safeguarding duties imposed on local authorities apply to an adult who:

- a) Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- b) Is experiencing, or at risk of, abuse or neglect; and
- c) As a result of those care and support needs is unable to protect themselves from either the risk of, or the experiencing of abuse or neglect.

This document will hereafter refer to the adult to whom safeguarding duties apply as Adults.

I.1.5 The Care Act also imposes a duty of co-operation between the local authority and other partners comprising the SAB. Section 6 (1) of the Act states that:

- 1) A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of:
  - a) their respective functions relating to adults with needs for care and support;
  - b) their respective functions relating to carers; and .
  - c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).

I.1.6 This SAR Protocol is designed to replace all previous Protocols.

## 1.2 Practice Guidance background

- 1.2.1 The Care Act 2014 imposes a duty on local authorities to establish a SAB and under section 44 of the Act; such Boards are required to make the arrangements necessary to undertake an SAR in certain circumstances.
- 1.2.2 The Act states that:
- 1) A 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 persons with relevant functions worked together to safeguard the adult;  
and
    - b. Condition 1 or 2 is met.
  - 2) Condition 1 is met if –
    - a. The adult has died, and
    - b. The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)
  - 3) Condition 2 is met if –
    - a. The adult is still alive, and
    - b. The SAB knows or suspects that the adult has experienced serious abuse or neglect.
  - 4) A SAB may arrange for there to be a review of any other 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).
  - 5) Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to –
    - a. Identifying the lessons to be learnt from the adult's case, and
    - b. Applying those lessons to future cases.

## 1.3 Purpose of a Safeguarding Adults Review

- 1.3.1 A SAR must be arranged when an adult in the Gateshead Local Authority area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Each SAR must make efforts to establish what the relevant agencies and individuals involved in the case in question might have done differently to prevent harm or death and findings of practical value to organisations and professionals should be published, setting out what action needs to be taken to prevent a reoccurrence.
- 1.3.2 The SAB will consider what type of review process could promote effective learning and improvement action to prevent future deaths or serious harm from occurring again. Such reviews will also be used to highlight areas of good practice where lessons learned can be identified to be applied to future cases.
- 1.3.3 Any SAR must reflect the six principles which underpin safeguarding:
- **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** – local solutions through services working with their communities, who have a part to play in preventing, detecting and reporting neglect and abuse; and
  - **Accountability** – accountability and transparency in delivering safeguarding.

- 1.3.4 The SAB will be responsible for agreeing the Terms of Reference for any SAR that they decide to undertake and this document will be published and made openly available. Records will be anonymised through redaction for the use within the SAR process unless informed consent is sought and given.
- 1.3.5 The SAB and its partner organisations will ensure that any SAR undertaken will apply the following principles:
- There will be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of Adults, identifying opportunities to draw on what works and promote good practice;
  - The approach taken to reviews will be proportionate and will depend on the scale, complexity and nature of the issues that are to be examined throughout the review;
  - It is essential that the SAR is led by individuals who are wholly independent of the case to be reviewed and of the organisations whose actions are being reviewed;
  - Professionals will be fully involved within the process and will be invited to contribute their perspectives to the SAR without fear of being blamed for actions taken in good faith;
  - Families will be invited to contribute to the SAR. Information will be given to the family members to ensure that they fully understand how they are going to be involved and what they can expect from a Review.
- 1.3.6 It is recognised that SARs must be trusted and safe experiences, carried out in an environment that encourages those participating in the process to be honest, transparent and willing to share information. The purpose of a SAR is **NOT**:
- To hold any individual or organisation to account
  - To reinvestigate or apportion blame.
  - To address professional negligence. (Should the review identify any necessary disciplinary action, this should be addressed through agencies' own Disciplinary Procedures. Individual Management Review (IMR) authors therefore need to be cognisant of their agency's disciplinary procedures.)
  - An Enquiry into how an adult at risk has died: that is a matter for the Coroner's Court.
  - An Enquiry into who is culpable for the death of that adult at risk - that is a matter for the Criminal Court.
  - A Judicial Inquiry: there is no oral evidence or cross-examination of evidence.
- However, the SAR will take account of a coroner's inquiry and criminal investigation.
- 1.3.7 It is acknowledged that agencies may have their own internal/statutory review procedures to investigate serious incidents; e.g. an NHS Serious and Untoward Incident Investigation. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.
- 1.3.8 The relevant SAB sub-group, will:
- Collate action points and Lessons Learned from individual SAR cases, ensuring that all outstanding actions are delivered and that Lessons Learned are clearly disseminated;
  - Collate and review recommendations from SARs from other authorities and best practice research to drive continuous improvement in Gateshead; and
  - Collate and review recommendations from all partner internal / statutory reviews i.e. statutory Domestic Homicide Reviews, Management reviews, Reflective Practice, Root Cause Analysis and After Action Reviews.
- 1.3.9 If the SAB decides to not implement any action or recommendation included emanating from the SAR then it must include the reasons for that decision within the Annual Report.

# Section 2: Operational Procedure

**2.1** The SAB should take the lead responsibility for conducting a SAR. The decision to undertake a SAR must be made a consensus. In the event that the Board members cannot reach a consensus, then the Chair of the SAB will make the final decision.

2.1.1 **A SAR must always be carried out if:**

- an adult at risk in the Gateshead Local Authority area who has care and support needs dies (including death by suicide), and when abuse or neglect is known or suspected to be a factor in their death; or
- an adult who is known or suspected to have suffered from abuse or neglect does not die but there is reasonable cause for concern about how the SAB or a member of it or any other person involved in the adults care acted;
- in any other situations involving an adult in the Gateshead Local Authority area with needs for care an support when there is a concern about how the SAB or a member of the SAB acted.

2.1.2 A SAR should be **considered** when:

- an adult has care and support needs, and when abuse or neglect is known or suspected to have taken place, and the adult has sustained:
  - A life threatening injury through abuse or neglect
  - Serious sexual abuse
  - Serious or permanent impairment of development through abuse or neglect;
  - Institutional or systemic abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a persons well-being and it is of a nature where there are serious negative outcomes for the individuals concerned;
  - Financial abuse where the outcome may not be life threatening but may have a long-term detrimental effect on a persons well-being and it is of a nature where there are serious negative outcomes for the individuals concerned;
- in any other situations involving an adult in the Gateshead Local Authority area with needs for care an support when there is a concern about how the SAB or a member of the SAB acted.
- the operational case details give reason for concern about the way in which professionals and services worked together to safeguard the adult at risk
- following a complaint, including those that are being investigated by the Local Government Ombudsman.

2.1.3 In deciding whether a SAR should be conducted in cases other than those involving a statutory obligation, the following questions should be considered by the relevant supporting SAB sub-group

- Was there clear evidence that the risk posed to an adult was not recognised, or shared, by professionals or agencies?
- Was the adult subject to a form of abuse or neglect as identified within the Care and Support Statutory Guidance [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)
- Does one or more professional, agency, family member, carer or advocate consider that their concerns were not taken seriously, or acted upon appropriately?

- Does the case indicate that there may be operational failings in one, or more aspects of the use of the SAB Policies and Procedures?
- Does the case appear to have implications for a range of professionals or agencies?
- Was the adult subject to unauthorised Deprivation of Liberty?
- Was there evidence of discrimination?

2.1.4 If the criteria for a SAR has been met and a death has occurred, the relevant supporting SAB sub-group is advised to liaise with their local Coroner's Office to ensure that the arrangements for undertaking a SAR are acceptable.

2.1.5 Due regard for criminal/civil process should be observed at all times by the relevant supporting SAB sub-group.

## 2.2 Initiating a Safeguarding Adults Review

2.2.1 Any agency or professional may refer a case that it believes confirms to the criteria and guidance (referred to in Section 4) using the format set out in Appendix C. The SAR referral should be submitted to the Business Manager – Safeguarding Adults.

2.2.2 All referrals will be submitted to the relevant sub-group of the Gateshead Safeguarding Adults Board for consideration. This sub-group will then be responsible for reviewing whether or not a referral meets the criteria. If the sub-group agrees that the referral meets the criteria then a recommendation will be submitted to the Chair for final approval. In the event of a Safeguarding Adults Review Referral being rejected, the reasons need to be recorded in writing by the Chair of the relevant SAB sub-group and shared with the applicant and the Chair of the SAB.

2.2.3 In certain cases, it may be necessary for the relevant supporting SAB sub-group to obtain additional information to enable a decision to be made as to whether a SAR is required. This may include asking key partners to submit initial chronologies to aid decision making.

2.2.4 Following approval, the relevant supporting SAB sub-group will be responsible for appointing an Independent Chair for the SAR Panel. The Independent Chair will also be the author of the final Overview Report.

2.2.5 There will be a need to address the budgetary requirements for undertaking a SAR. This will be the responsibility of the SAR.

## 2.3. Conducting a Safeguarding Adults Review

2.3.1 The Chair of the Safeguarding Adults Review Panel will be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to stages described below and the agreed timescales (Appendix D).

### 2.3.2 Stage 1 – Establish a Safeguarding Adults Review Panel

The first task of the Independent Chair will be to establish a Serious Case Review Panel. Members of the relevant supporting SAB sub-group will be the core members of the Safeguarding Adults Review Panel. Additional members may be co-opted by the Chair for their individual skills and experience relating the individual case. In order to enhance the independence and objectivity of the panel, nominees selected to contribute to specific reviews will normally be chosen from an operational area that has no direct involvement with the case in question.

### 2.3.3 Stage 2 - Initial Meeting

The Initial Meeting will agree:

- The Terms of Reference. This document will address the following elements:
  - What appear to be the most important issues to consider in order to enhance the points of learning from the specific case?

- How can the relevant information best be obtained and analysed, including any necessity to request relevant individuals to give a direct account?
- Over what time span should case details and chronology of intervention be reviewed?
- What information from family, or service, history will assist the Safeguarding Adults Review Panel?
- Which agencies or individuals should contribute to the review, and is there a need for other written information to be obtained from other sources?
- Should the adult at risk, their family, carers or advocates be invited to contribute to the review? If so, which is the most appropriate method to enable their participation?
- Should an independent advocate be appointed to represent and support an adult who is the subject to the SAR? (NB: where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them an independent advocate must be appointed.)
- How should the review process take account of a Coroner's inquiry, or any criminal investigation?
- When should the review start and by what date should it be completed?
- How will confidential information be recorded, stored, and distributed?
- What best practice operational guidance / procedures can be used as a benchmark to measure individual / agency performance?
- the 'evidence' required from each participant to be contained within an Individual Management Review. The Chair of the Safeguarding Adults Review Panel will formally request agencies to prepare and submit an Individual Management Review outlining their involvement with the adult at risk/family (Appendix A).
- the support and other resources needed (any perceived deficits to be referred to Chair of SAB)
- the time scales within which the review process should be completed with
- dates, times and venues of meetings
- the nature and extent of legal advice required, in particular relating to:
  - Data Protection; Freedom of Information considerations and the implications of the Human Rights Act 1998.
- whether there is the need for the completion and implementation of media and communication strategies
- how the adult at risk, family, friends and carers will be involved in the process. The views of the adult at risk and or family and carers must be sought as part of the review and the way that agencies interacted with the adult and family / carers will always be a relevant consideration for any IMR
- that all records are secured immediately and made available to the IMR author

#### 2.3.4 **Stage 3 – Evidence Gathering**

Each agency asked to complete an IMR will inform the Chair of the name of the IMR author(s). The IMR authors will be invited to meet with the Chair, to ensure a consistent approach and to identify and resolve any barriers to completing the work. The IMRs will incorporate a detailed chronology of events, highlighting any discrepancies. IMRs will also provide recommendations for action. IMRs MUST be quality assured and signed by the relevant agency representative on the Safeguarding Adults Review Panel prior to submission.

#### 2.3.5 **Stage 4 – Receipt of evidence**

This stage of the process is a formal session where agencies will share their IMRs and all other relevant information. IMR authors may be invited to the meeting to clarify and raise queries from their reports. All information must be submitted to the Chair prior to the meeting. Each agency involved will be asked to:

- Present their Individual Management Review and any other management reports and relevant information

- Cross-reference all agency management reports and reports commissioned from any other source
- Form a view on practice and procedural issues
- Agree the key points to be included in the final Overview Report and the proposals for action

2.3.6 If at any stage whilst undertaking the procedure information is received which requires notification to a statutory body, e.g. General Social Care Council (GSCC) or DfeS, regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay. The Chair of the Safeguarding Adults Review Panel should report back to the Chair of the Safeguarding Adults Board and a decision made as to whether the SAR process should be suspended pending the outcome of such notification.

### 2.3.7 **Stage 5 – Production of the Overview Report**

The Safeguarding Adults Review Panel will advise the Chair on the production of the Overview Report, which brings together information, analyses it and makes recommendations. The SAR report should:

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

The Independent Chair will produce the report within agreed timescales. The Safeguarding Adults Review Panel will monitor and ensure quality assurance of the overview report to ensure it meets the required standard for the Safeguarding Adults Board.

### 2.3.8 **Stage 6 - Implementing the review recommendations**

On completion, the Overview Report will be presented to the Safeguarding Adults Board, which will:-

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report.
- Ensure that the Overview Report contains an Executive Summary which can be made public, including key learning points for agencies.

2.3.9 The action plan will indicate:

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

# Section 3: Quality Assurance

## **3.1 Governance and Accountability**

- 3.1.1 The relevant supporting SAB sub-group will ensure that all planned actions are implemented. The action plan will remain on the relevant supporting SAB sub-group agenda until such time that all recommendations have been implemented.
- 3.1.2 All Safeguarding Adults Reviews conducted within the year should be referenced within the Safeguarding Adults Board's Annual Report and Strategic Plan along with relevant service improvements.
- 3.1.3 The relevant supporting SAB sub-group will be responsible, on behalf of the Safeguarding Adults Board, for sharing Lessons Learned throughout the partnership and disseminating good practice.

## **3.2 Performance Monitoring**

- 3.2.1 There will be an evaluation of each Safeguarding Adults Review to ensure that due process was followed and that appropriate arrangements were made to engage the family members of the service user.
- 3.2.2 The findings of any SAR will be documented in the Safeguarding Adults Board's Annual Report, as well as what action has been taken or will be taken in relation to the findings.

## **3.3 Practice Guidance Review**

- 3.3.1 This guidance note will be reviewed on an annual basis and in accordance with legislation.

# Appendix A

## Individual Management Reviews

### IMR Procedure

1. When a case conforms to the criteria for conducting a Safeguarding Adults Review, the Chair of the Safeguarding Adults Review Panel will formally request that agencies conduct an Individual Management Review (IMR) of their involvement with the adult at risk, the service, and/or their family/carers. Upon conclusion of this IMR the agency should submit a report detailing their findings.
2. The request for the IMR and report will be addressed to the chief officer or chief executive of the agency concerned. Although the task of completing the IMR and report may be delegated to a suitably qualified senior manager within the agency, it is crucial that the final report and recommendations within are fully endorsed by the chief officer before submission.
3. On receipt of the request from the Safeguarding Adults Review Panel, it is recommended that agencies should take action to secure all relevant records relating to the case, thus guarding against loss or interference.
4. The aim of the IMR is to look openly and critically at individual and organisational practice to identify whether the case indicates that changes could, and should, be made and, if so, how these changes will be achieved.
5. The Safeguarding Adults Review is not part of any disciplinary inquiry. However, information that emerges in the course of the review may indicate that disciplinary action should be taken under established agency procedures.
6. Where staff or others are interviewed by those preparing management reviews then a written record of such should be made and this should be shared with the interviewee.

### IMR Template

#### What was the agency's involvement with the adult and family?

A comprehensive chronology should be compiled of involvement by the agency and its employees over the period of time specified by the Safeguarding Adults Review Panel.

Date and Time	Source	Reason for Presentation	Professional Observation	Other Comment

### Analysis of Involvement

Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgements were made which indicate that practice, or management that could be improved then try to get an understanding not only of what occurred, but why. For example:

- Were practitioners sensitive to the needs of the adult at risk and their family / carers?
- Were they knowledgeable about potential indicators of abuse or neglect?
- Were practitioners, or was the agency, clear about its' roles and responsibilities in protecting adults at risk from abuse?

- Did the agency have policies and procedures for safeguarding adults at risk?
- What were the key relevant points/opportunities for assessment and decision making in this case?
- Do these assessments, or decisions, appear to have been made in an informed and professional way?
- Did subsequent actions accord with any assessments or decisions made?
- Were appropriate services offered or provided in light of the assessment?
- Were care plans reviewed?
- Were the views and feelings of the adult at risk, family, or referring body ascertained? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic, and religious identity of the adult, family, or family carer?
- Was information shared appropriately in order to alert other managers or agencies of concerns?
- Was the work in this case consistent with the agency's and Safeguarding Adults Board Multi-Agency Policies and Procedures?
- Was Mental Capacity considered?
- Were there issues associated with discrimination?

### What has been learned from the case?

- Are there lessons from this case for the way in which this agency works to safeguard adults at risk and promote their welfare?
- Are there examples of good practice, or ways in which practice could be improved?
- Are there implications for ways of working; training (single and multi-agency); management and supervision; working in partnership with partner agencies; shortfalls in resources or service provision?

### Recommendations for action?

- What action should be taken, by whom, and by when?
- What outcomes should these actions bring about?
- How will the agency review whether they have been achieved?

<b>Recommendation for action</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Required Outcome</b>	<b>Lead Officer/ Organisation</b>	<b>Target Date</b>

A report of the management review should be completed, endorsed by the agency's chief officer and sent to the Chairperson of the Safeguarding Adults Review Panel. Any foreseeable delays should be communicated as a matter of urgency.

# Appendix B

## Overview Report by Safeguarding Adults Review Panel Chair

**I. The Safeguarding Adults Review Panel chair will produce an Overview Report set out in the following format:**

### **Introduction**

- Summary of circumstances that led to the review being undertaken
- Terms of reference of the Safeguarding Adults Review
- List of contributors to the review and the nature of their contribution.

### **The Report Detail**

- Details of the family and care services provided
- A detailed multi-agency chronology
- Summaries of information known to the agencies and professionals involved about the adult, family, family carer, or perpetrator.

### **Analysis**

- Examination of how, and why, events occurred, including decisions made, actions taken, or omitted. Reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have resulted in an alternative course of events. This section should also highlight good practice.

### **Conclusion**

A summary of the lessons that, in the opinion of the Safeguarding Adults Review Panel, are to be drawn from the case and how these lessons should be translated into recommendations for action. These recommendations should be focussed, specific and achievable. If there are lessons for national, as well as local, policy and practice, then these too should be highlighted.

The Overview Report will include an Executive Summary which will be disseminated on permission of the Chair of the Safeguarding Adults Board.

# Appendix C

## Gateshead Safeguarding Adults Review Referral

### **GATESHEAD SAFEGUARDING ADULTS REVIEW REFERRAL**

#### **Referrer Details**

Name:

Job Title:

Organisation:

Telephone:

Email:

Address:

Date Referral submitted:

#### **Details of Adult Concerned**

Name:

Address:

Date of Birth:

Date of Death (If applicable):

Ethnicity:

Name and Address of GP:

Family / Next of Kin / Advocate / Representative:

Agencies involved:

Name of Safeguarding Adult Manager - SAM (If applicable):

Relationship with perpetrator (If applicable):

*Continued on next page*



Summary of why, in your opinion, this case could be considered for a Safeguarding Adults Review using the agreed criteria:

**Submit this form to:**

Business Manager – Safeguarding Adults, Gateshead Council, Community Based Services, Safer Communities Team, Civic Centre, Regent Street, Gateshead. NE 8 1HH

# Appendix D

## Safeguarding Adults Review Timescales

Process	Timescale
The relevant supporting SAB sub-group will consider SAR referral	Within 6 weeks of submission to Business Manager – Safeguarding Adults
Chair of SAB approval	Within two weeks of the sub-group decision to recommend a SAR
Appointment of Independent Chair of the Safeguarding Adults Review Panel	Within one month of the SAB Chair approval (this is to enable appropriate commissioning arrangements)
Initial Safeguarding Adults Review Panel Meeting	Within one month of appointment of Independent Chair
Production of Overview Report and final approval of the relevant supporting SAB sub-group	Within four months of Initial meeting
Presentation of the Overview Report to the Safeguarding Adults Board	To be submitted to the first Safeguarding Adults Board that is scheduled following approval of the Overview Report by the relevant supporting SAB sub-group'

### Gateshead Safeguarding Adults the relevant supporting SAB sub-group

Date referral received:

Date considered by Supporting Sub-Group:

Decisions / Action Taken



**If you would like any more information or to discuss this document further - please contact a member of the Safeguarding Adults Co-ordination Team on 0191 433 2378.**

**If you would like this information in a different format such as large print, Braille, on audio cassette/CD/MP3 or in a different language, please call 0191 433 3990.**