Cheshire West and Chester
Local Safeguarding Adults Board (LSAB)

Safeguarding Adult Reviews (SARs)

Procedure

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Local Safeguarding Adults Board

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Cheshire West and Chester Safeguarding Adults Review (SAR) Procedure

1. Introduction

1.1 The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in section 1 of the 2014 Care Act (implemented in April 2015). It is a statutory requirement of Adult Safeguarding Boards to carry this function out.

1.2 Cheshire West and Chester (CWaC) Local Safeguarding Adults Board (LSAB) oversees and leads adult safeguarding across the locality and has a range of statutory duties that contribute to the prevention of abuse and neglect. This includes the duty to conduct any SARs in accordance with section 44 of the Care Act. SARs are reviews that examine the way agencies and individuals have acted when they have been involved with an 'adult at risk'. The purpose of the SAR is to identify learning that will bring about improvements so that the likelihood of harm to adults at risk is minimised.

1.3 This procedure specifies the statutory requirements and the working arrangement arrangements of Cheshire West and Chester LSAB in respect of SARs.

1.4 SARs are not to reinvestigate or apportion blame. The purpose is not to make an enquiry into who is culpable or how the person met their death – these matters are for the Coroners Court, Criminal Courts and employment procedures as appropriate.

2. Statutory Duty under Section 44, 2014 Care Act

2.1 There are three broad circumstances under which the Care Act statutory guidance considers a SAR may take place. The guidance makes a distinction between those circumstances where the LSAB ***must*** and ***may*** arrange a SAR:

2.2 The LSAB ***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:

1. There is reasonable cause for concern about how the LSAB, members of it or other persons with relevant functions worked together to safeguard the adult and:
2. EITHER

   a) the adult has died and the LSAB 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).

   OR

   b) the adult is still alive, and the LSAB knows or suspects that the adult has

experienced serious abuse or neglect (serious may be defined as life changing injury/condition).

2.3 A LSAB ***may*** also 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). 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. In cases where there is learning but the case does not meet the thresholds for a full SAR then a discretionary SAR can be considered.
All criteria need to be met.

2.4 Each member of the LSAB must co-operate 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.

3. Safeguarding Adult Review Criteria

3.1 The first criterion for determining whether a SAR should be conducted is in establishing whether the adult was in need of care and support services (whether or not the local authority was meeting any of those needs).

3.1.1 The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014 (the 'Eligibility Regulations'). The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing.

3.1.2 In considering whether an adult has eligible needs for care and support, local authorities must consider whether:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of adult's needs the adult is unable to achieve two or more of the specified As a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes (which are described in the Care Act guidance sections 6.105 to 6.112)
- As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

3.1.3 Significant impact is not defined and should be understood to have its everyday meaning.

3.2 The second criterion to be met is establishing a cause for concern about how the LSAB, its member organisations, or other persons with relevant functions, worked together to safeguard the adult. A particular emphasis is the extent that they could have worked more effectively to protect the adult from the resultant outcome and therefore the potential for learning.

3.3 The third criterion involves an examination of the link between the death or serious harm (what constitutes serious harm is detailed in 3.4) and suspected abuse or neglect.

3.4 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 as a result of the abuse or neglect.

3.5 **Timescales** – any learning from a review should be current or recent, therefore any request for an SAR should be within 12 months of the alleged abuse/incident occurring

3.6 All three criteria must be met for the panel to say that a SAR must be carried out and needs to set out as much information regarding those three criteria where possible.

3.7 A discretionary SAR can be carried out if its unclear that all the criteria is met but there is multi agency learning.

4. SAR Referral Process

4.1 A referral is made by completing the referral form, which can be downloaded on the LSAB website SAR referral form and sent by secure email, which is password protected or encrypted, to the LSAB Board Manager or Administrator. Referrals should be made as soon as it is apparent that the criteria may be met, subject to considerations in paragraphs 4.2 and 4.3 below. An unreasonable delay in raising an issue can impact both on the process and the key purpose in several ways**.**

4.2 The LSAB will not review cases that are more than twelve months old, unless there is significant information that has recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. The decision to take on cases that go outside the time limit, need to be referred to the LSAB Independent Chair for a final decision.

4.3 Prior to making a referral, professionals working with adults at risk, should consider the relevant guidance, and discuss with their organisations line manager, Safeguarding lead (if applicable) or LSAB representative.

5. Decision Making

5.1 On receipt of the SAR referral request, the Chair of the SAR Panel, supported by the Safeguarding Adults Board Manager, will discuss with members of the panel to consider whether the criteria are met.

5.2 To support the decision-making process, professionals known to be involved will be asked to complete a pre-screening form setting out details

of their known involvement. Professionals involved in the case may be asked to attend part of the meeting to provide context and clarification on the circumstances of the case.

5.3 The Chair of the SAR Panel may seek further information including clarity about parallel investigations that may be taking place such as 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.

5.4 Agencies can be asked for additional information by the LSAB Board Manager to inform a decision as to whether a review should take place. After reviewing all the information available against the criteria and guidance, the SAR Panel will determine if they consider that the criteria for a SAR have or have not been met.

5.5 The Independent Chair of the Safeguarding Board is responsible for deciding whether to undertake a review or not, based on the recommendations from the SAR Panel.

5.6 The Chair of the SAR Panel will inform the referrer in writing of the decision. If the referrer does not agree with the decision, they may appeal to the Independent Chair of the LSAB, whose decision is final.

5.7 If the decision is to undertake a SAR, the LSAB Board Manager will arrange to notify the individual, their family, or carers (where appropriate), collaborative agencies of the Board, and if applicable to do so, the Care Quality Commission (CQC) which is the regulator of health and social care services.

5.8 Where the SAR Panel agrees that a referral does not meet the criteria for a SAR but agencies will benefit from a review then a discretionary SAR should be considered.

5.9 All referrals will be noted and recorded.

6. The SAR Panel

6.1 The SAR Panel is made up of the following partners who are:
Cheshire Constabulary (chair)
Cheshire West and Chester Head of Service or Senior Adult Social Care Manager or Team Manager
NHS Cheshire & Merseyside Integrated Care Board Cheshire West Place
LSAB Board Manager and Administrator

Agencies involved in the SAR will be invited to attend future meetings.

7. Commissioning a SAR

7.1 On receipt of the decision to undertake a SAR then the initial panel meeting with look at the following:-

- A draft scope (Terms of Reference) for the review
- The type of review to be undertaken and the methodology
- The key roles required such as SAR Panel Chair/ Independent Author/ Independent Facilitator/SAR panel
- Links with any other parallel processes such as a SCR, DHR or LeDER review
- Liaison with other interested parties (e.g. Adult/those affected, Coroners, Crown Prosecution Service, commissioning and regulatory bodies such as Care Quality Commission)
- SAR Panel membership
- Timescales

7.2 It is to be noted that in determining the type of review and methodology to be used that the statutory safeguarding principles will be applied. The focus will be on ensuring that there is an effective and proportionate means by which the SAB can identify key learning so that it can fulfil its statutory obligation to help protect adults in its area.

7.3 Following consultation and agreement with The Independent Chair as to the above, the arrangements for the SAR to commence will be made

7.4 The Panel will then agree the approach and plan the practical arrangements necessary to implement and commence the SAR process. This will include the appointment to the key roles required and the coordination of the relevant information.

8. Clarity of purpose

8.1 The purpose of a SAR is to promote effective learning and improvement action, through identifying what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an investigation.

8.2 The SAR's purpose is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

8.3 A SAR should highlight any lessons that can be learned from the case and through a clear set of recommendations; ensure that relevant actions are taken to help prevent future deaths or serious harm. This helps to improve both single and multi-agency working to better safeguard and promote the wellbeing of adults at risk.

8.4.1 SARs will be undertaken in accordance with the following principles:

- There should be a multi-agency culture of continuous learning and improvement; identifying opportunities to draw on what works and promote good practice.
- The approach should be proportionate according to the scale and complexity of the issues and the potential for learning.
- SARs should be led by individuals who are independent of the case and of the organisations whose actions are being reviewed, with the skills and experience necessary to maximise learning.
- SARs should be trusted and safe experiences that encourage honesty, transparency and sharing of information. People, who are invited to contribute, should do so without fear of being blamed for actions they took in good faith.
- SARs should be underpinned by a culture of openness, transparency and candour. This should be reflected in the involvement of people affected by the case including the victims of abuse and their families.
- Recommendations and learning will be shared appropriately through local and regional safeguarding networks to ensure that good practice is made available to those who work closely with adults at risk and those who assist to influence and develop practice in this arena.

9. Governance

9.1 Only Cheshire West and Chester Local Safeguarding Adults Board Chair can commission a Safeguarding Adults Review; however any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR

9.2 Where an individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they may refer a case to the LSAB to establish if there are important lessons for multi-agency work to be learnt from a case. This includes any professional body, members of the public, councillors, MPs, and the coroner. The Secretary of State also has authority under the Local Authority Social Services Act (1970) to cause an enquiry to be held where he/she considers it advisable.

9.3 LSAB member organisations will publicise within their own agencies the criteria and circumstances under which a SAR may be considered and the process under which a referral might be made. This information will also be publicly accessible.

9.4 By virtue of the criteria, in cases where a SAR may be indicated, a safeguarding concern and/or enquiry may already have been made. In this case a discussion with the relevant manager who was responsible for authorising the case should normally take place prior to making a referral for a SAR. Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to multi-agency

safeguarding policy and procedures which consider any immediate protection required.

9.5 However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have committed suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

9.6 All agencies should have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning, and this protocol is not intended to duplicate or replace these.

9.7 Action plans will be overseen by the LSAB.

10. Commissioning a SAR

10.1 The Care Act guidance states that the LSAB should aim for completion of a SAR within a reasonable period and in any event within 12 months of initiating it unless there are good reasons for a longer period being required.

10.2 It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues, which emerge from the review and need to be considered immediately, should be brought to the attention of the Board.

10.3 On receipt of the LSAB Chair's decision to undertake a SAR, the SAR Panel Chair and the LSAB Board Manager will liaise in order to make the necessary arrangements. This will include:

- Notifying the referring agency, LSAB members and other interested parties (including CQC and the coroner).
- Identifying an appropriately qualified Independent Chair/Author and securing the necessary administrative support and budgetary requirements.
- Notifying the adult and/or their family/advocate as appropriate.
- Considering an initial scope and timescales.
- Initiating any information requests that are required.
- Considering media and communication strategies.

10.4 Once the decision has been communicated, each agency will be responsible for taking appropriate actions that may be necessary in relation to the security of their records. No member agency should comment publicly upon the case without express agreement of both their senior management and the Independent Chair of the LSAB.

11. Appointment and Role for the Review Panel Chair/Author

11.1 There is a separate process that the Board Manager carries out to recruit a Review Panel Chair/Author.

11.2 The Review Panel Chair/Author should be an experienced individual who has specialist knowledge in the subjects the SAR needs to cover and who is not directly associated with any of the agencies involved in the Review. The Review Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the
Individual Management Reviews (IMRs) and any other evidence the SAR Panel decides is relevant.

11.3 Consideration should be given to the skills and expertise required to effectively Chair a SAR. The Review Panel Chair/Author should have the appropriate core skills including:

- 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;
- Ability to find and evaluate best practice;
- Good analytic skills and ability to manage quantitative and qualitative data;
- Knowledge of safeguarding adults;
- Ability to write for a wide audience and
- An understanding of the complexity of the health and social care system.

11.4 The Review Panel Chair/Author is responsible for the final decision on the suitability of the SAR Terms of Reference, and they are to be drafted at the first meeting of the Panel.

11.5 The Terms of Reference may, however, need to be revisited as the Review progresses and as new information is identified. The Review Panel Chair/Author will agree any amendments to the Terms of Reference with the SAR Panel.

11.6 The Review Panel Chair/Author will establish an agreed timetable of SAR Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of Individual Management Reviews.

11.7 As part of the Terms of Reference, the Review Panel Chair/Author should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.

- Contact point for responding to media interest about the Review in conjunction with Cheshire West and Chester's Council's Communications Team.

11.8 The Review Panel Chair/Author should as far as possible, ensure that the Review process is a learning exercise in itself for all those involved in the case.

11.9 The Review Panel Chair/Author will maintain contact with the LSAB Board Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

11.10 The Review Panel Chair/Author should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

11.11 Where there is an on-going criminal investigation the Review Panel Chair/Author will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes.

11.12 This relates particularly to any planned interviews with family members, practitioners and managers and must consider that any one of these people may be potential witnesses or even defendants in a future criminal trial.

12. Management of SARs

12.1 The SAR process will be managed by the statutory partners and where there is any disagreement that cannot be resolved between the partners then the SAR panel Chair will make the decision and if there is still no resolution then the LSAB Independent Chair will make the final decision. The report is the property of the LSAB.

13 Methodology

13.1 SARs can be conducted in a variety of ways and the appropriate methodology will be used.

13.2 In the event a SAR isn't agreed then see section 11.

14. Parallel processes

14.1 There are a number of types of review and investigation that may interface with a SAR and it is important to identify any other processes which may be running in parallel or being considered. These include a Child Serious Case Review (SCR), Domestic Homicide Review (DHR), safeguarding and serious incident investigations, criminal justice processes and Coroner inquests.

14.2 In setting up a SAR, the LSAB must consider how the SAR will dovetail with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness, and learning; and minimising the impact on those affected by the case.

14.3 Where there are possible grounds for both a SAR and a Child SCR or a DHR then a decision should be made at the outset by the respective decision-making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one Board leading, with the same or different reports being taken to each commissioning body.

14.4 Any SAR will need to take account of a coroner's enquiry and, or any criminal investigation including disclosure issues, which may impact on timescales. It will be the Chair of the SAR Panel – to ensure the necessary contacts are maintained with appropriate people.

15. Informing the person, members of their family and social network

15.1 Family members and friends can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the SAR Panel have opportunities to listen to family and friends' experiences and perspectives and that these contribute meaningfully to the final report.

15.2 Reflecting the principles of openness, transparency and candour; the LSAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care Act, where an adult has "substantial difficulty" in participating, this should involve representation and support from an independent advocate (who could be a family member).

15.3 Staff involved in the SAR need to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how a known abuser might have some input to the review process.

15.4 Normally, individuals should be notified that the SAR Panel is taking place. Involvement may be by formal notification only, or by inviting them to share their views in a way that suits them.

15.5 If a decision is taken not to involve the adult at risk, or their family, the reasons should be informed by legal advice and recorded.

16. **Considerations for Disclosure in a Safeguarding Adults Review**

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public
- authorities, known as the 'right to know', came into force in January 2005.
- Consideration of relevant articles of the European Convention of Human Rights, as incorporated into the Human Rights Act (1998)
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act (1998) & Children Act (1989) (updated 2004).
- Information sharing between LSAB's and the Coroner is not defined in statute however case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the LSAB has commissioned a SAR, information sharing in relation to SAR documents should be considered on a case-by-case basis.

16.2 On receipt of a request for documents relating to a SAR, from the Coroner, the LSAB will seek legal advice in order to consider Public Interests Immunity arguments.

16.3 Chapter 14 of the Care Act Guidance sets out expectations in relation to information sharing between agencies and LSABs in relation to SARs including an expectation that information must be shared to enable a LSAB to do its job.

17. Assembling Information

Chronologies are important tools particularly when combined across organisations. This enables a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment.

Many of the methodologies outlined utilise chronologies within them, however they can be used in isolation to achieve an overview of a case simply, that can assist in assuring or developing multi-agency working.

In this approach each agency produces a single chronology of involvement over the period that has been agreed as relevant to the investigation or review. They may also be asked to provide chronologies relating to more than one person of interest in the case.

Please note it is not a copy and paste exercise of case notes. As part of the SAR process the author/reviewer will meet with the agencies being asked to complete a chronology to provide advice on how to complete them.

The chronologies are then combined in a desk top exercise. This enables review by an individual, for example in determining whether there appears to be grounds for further investigation or potential for learning; or where this is the case, more detailed examination and discussion in a multi-agency workshop. This latter process will usually benefit from a facilitator.

Any identified learning points should be noted and translated into actions which are shared with the LSAB and implemented.

Individual Management Reviews (IMRs) are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes, or individual and organisational practice could be enhanced. They are key learning tools used in several of the SAR methodologies and other similar reviews such as Domestic Homicide Reviews and Serious Case Reviews. They can be used in a multi or single agency environment.

It is important that individuals who are asked to undertake IMRs have the relevant skills and sufficient independence from the case being reviewed.

Where it is decided that IMRs are required:

- The SAR Panel should write to the Chief Officer of the organisations involved, providing the template for an IMR.
- Organisational reports should be prepared by a Senior Officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learnt and actions taken or to be taken.
- Individual Management Reviews must be signed off by the Chief Officer of each organisation.

As part of the SAR process the author/reviewer will meet with the agencies being asked to complete an IMR to provide advice on how to complete them.

18. Practitioners Involvement

As part of the SAR process any practitioner and their direct line manager, not the SAR panel representative, will be invited to a practitioners event

with the author/reviewer so that panel can get a lived experience of the person who the SAR is about and the type of care they received.

19. Analysis

The value of SARs is in the learning derived from them. As such much effort should be spent on acting on recommendations as on conducting the actual Review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timely.

19.1 The following should help to secure maximum benefit from the Review:

- Conduct the Review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a Review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with adults.
- Make sure staff and their representatives understand what can be expected in the event of a SAR.

20. The Report

20.1 The report brings together the learning, themes identified from the review and will analyse and comment on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the adult.

20.2 The Review Panel Author has responsibility for collating the report and the report should:

- Provide a summary of the circumstances that led to the review.
- Briefly outline the review process and methodology, including how the views and participation of key stakeholders as achieved.
- Be written in a succinct and focused manner with the emphasis on recognising and sustaining good practice as well as identifying how and where practice can be improved in the future.
- Identify action that agencies or services have already undertaken in response to learning.
- Form a conclusion as to the effectiveness of local practice to safeguard and promote the welfare of the adult.
- Not have any identifying information where possible and is annoymised.

The report should firstly be presented to the SAR Panel. This provides an opportunity to quality assure the document, reference the identified learning and to ensure an opportunity for the findings to be challenged where necessary. The panel will be responsible for agreeing the final content.

The report should also be presented to those who have contributed to the content for the additional panel members to quality assure.

20.3 Once agreed the Author will be asked to present the report to the LSAB supported by the SAR Panel Chair.

20.4 The report will be the property of the LSAB and as such partners will be expected to identify and agree how practice challenges or recommendations from the report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

21. Publication and dissemination

21.1 There is a statutory duty to publish the findings of SAR's, however the method of publication and the extent of publication is decided by LSAB Members.

21.2 SAR Report publication may be impacted by other parallel processes such as criminal proceedings/ court cases, alongside data sensitivity issues that may impact on those who have been impacted by the case. Whilst publication of the report may be held for publication, the lessons learnt and recommendations can be taken forward once the LSAB Members have agreed the report.

21.3 Decisions in relation to publication will consider the view of the SAR Panel, the adult, family members and/ or advocates and any potential impact on those involved in the case.

21.4 LSAB Members will consider how findings of the SAR will be disseminated to interested parties and will confirm to whom the SAR Report will be made available. It is expected that LSAB Members will disseminate learning within their agencies, implement identified actions and de-brief and support practitioners involved in the case.

21.5 General themes and outcomes of SAR's will be reported in the LSAB Annual Report, with overviews and any resulting practice guidance/ resources for practitioners made available on the website.

21.6 LSAB will also contribute information on the SAR to the national SAR repository, collated by SCIE to support the wider safeguarding agenda

21.7 Once the report has been endorsed and signed off by the LSAB then the Board will make the final decision to publish the full report or the executive summary.

21.8 Media and communication issues will usually be co-ordinated by the Council's Communications Team. This will be done in collaboration with the Communications Teams of the other agencies involved, alongside agreed representatives of the Board.

21.9 A practitioner event will be held to present the findings to the wider workforce.

21.10 An action plan will be developed to look at improvement and will be monitored by the Quality Assurance subgroup and reported to board through the quarterly reports.

21.11 Partners will be asked to report to board an evaluation on the impact of the actions.

21.12 Published SARs will be reported on in the Annual Report.

21.13 Findings, learnings and recommendations will be presented to the joint Local Safeguarding Adults Board and Safeguarding Children's Partnership Training and Development Hub.

22. Complaints & Escalation procedure

22.1 Where a complaint is received regarding the SAR process this will initially be responded to by the LSAB Board Manager in consultation with the SAR Chair, with a written response within 28 days of receipt.

22.2 If the complainant is unsatisfied with the response, they should contact the LSAB Board Manager who will arrange for their complaint to be considered by the LSAB Independent Chair.

22.3 The LSAB Independent Chair will provide a further written response within 28 days of the complainant contacting the LSAB Board Manager. All written complaint responses will include details of how to contact the Local Government Ombudsman.

22.4 The LSAB Board Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of the General Data Protection legislation.

Appendix 1 SAR referral process