National Network for Chairs of Adult Safeguarding Boards

SAB MANAGER NETWORK

Interface between SARs and Coronial Processes

Best Practice Guidance

September 2024

Interface between SARs and Coronial Processes Best Practice Guidance

This guidance has been developed by the National Safeguarding Adults Board Manager Network in response to feedback from Safeguarding Adults Boards (SABs) and learning from Safeguarding Adults Reviews (SARs) that the interface between SARs and Coronial Processes can be difficult to navigate. Practice across the country has been variable.

Legislation covering crossover of these two processes is limited, and so SABs and Coroners do not have a standard approach to ensuring these parallel processes, when running concurrently, can proceed as efficiently and effectively as possible. It is essential that both SABs and Coroners are able to undertake their respective statutory obligations without compromising those respective tasks or causing distress to the family of the deceased.

This briefing contains an overview of legislative guidelines, good practice guidance, helpful tools and templates, and examples of local protocols, and has been developed to inform local working arrangements and support a joined-up approach. This guidance is not intended to replace any legal requirements or local joint working arrangements currently in place.

This guidance aims to help identify how, when, and why joint working might be requested and/or required and helpful. The aim is to minimise delays in respective statutory processes, as well as keeping one another informed regarding the decision-making process. The aim is also to manage the expectations of the family of the deceased.

This guidance can be used locally to:

- Provide clarity about roles and responsibilities
- Outline any legislative duties and areas of crossover
- Create a better understanding of each other's processes
- Provide a starting point for developing a local protocol if you do not already have one
- Provide useful tools to assist communication
- Enhance positive joint working
- Reduce duplication
- Act as a 'check' of existing local protocols to see if any areas could be strengthened
- Inform a review of local protocols

This best practice guidance was informed by learning from Safeguarding Adults Reviews and a National Survey sent to Safeguarding Adults Boards and Safeguarding Adults Reviewers. We would like to acknowledge the valuable contributions made by a small reference group of SAB Managers, Coroners, Independent SAB Chairs and a legal representative.

Contents

Overview of Relevant Processes

This section covers the following questions and points raised through the National Survey and Workshops:

- **Is there any guidance on how the two processes should interact?**
- **How can we reduce misunderstandings around SARs and Inquests?**
- **How can we better understand each other's processes?**
- **How can we reduce duplication and minimise confusion and distress for families?**
- **What are the 'SAR Quality Markers' and how are they applied?**
- **Clarity around the change in responsibility for SARs since the Care Act (2014)**
- **Clarity around the difference between the Care Act (2014) S42 and S44 and the roles of Adult Social Care and the SAB to ensure they are not confused**
- **What are the statutory obligations, timescales and aims of each process?**

- Although SARs, Safeguarding Enquiries and Inquests are all statutory processes, they all have different leads, remits, timescales and legislative frameworks. Each case is considered against a set of legislative criteria. Not all referrals result in either a SAR or a safeguarding enquiry. Not all deaths become the focus of an inquest. There may be an Inquest but no SAR and vice versa; processes may not necessarily occur simultaneously or in any sequence.
- Delays in SARs and Inquests have an impact on the bereaved families involved, so it is important to manage delays wherever possible.
- Both processes can happen independently and do not have to be coordinated; however, there can be benefits from keeping each other informed so this is something that SABs and Coroners need to consider.

What is a SAR?

- Under Section 44 of the Care Act (2014) SABs must arrange a SAR when an adult in its area with needs for care and support dies as a result of abuse or neglect, whether known or suspected, and there is concern that agencies could have worked more effectively to protect the adult. A SAB must also arrange a SAR if an adult in its area with needs for care and support has not died, but it is known or suspected that the adult has experienced serious abuse or neglect and there is concern that agencies could have worked more effectively to protect the adult (section 44 (1) (2) (3)).

- Where these criteria are not fully met, a SAB may exercise its discretion to commission a SAR in relation to any other case involving an adult with care and support needs (section 44 (4)).
- 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.
- Prior to the Care Act (2014), the Local Authority held the responsibility for SARs and they were termed Serious Case Reviews. The introduction of the Care Act (2014) meant a significant change and means the Local Authority no longer decides whether cases meet SAR criteria, determines how these reviews are commissioned, makes decisions about SARs, owns the information or has oversight of the resulting recommendations. These are now the responsibilities of Safeguarding Adults Boards. [SAB]. SABs are separate entities from the local authority; it is usually a wide partnership of relevant organisations, three statutory core agencies (local police, integrated care board and local authority) are required to participate.
- Implementing governance for SABs under the Care Act (2014) means that decision making, commissioning, and overall responsibility is multi-agency, remains the responsibility of the SAB, and does not sit with any one person, team or agency. This means that queries regarding SARs should be directed to your local SAB rather than the Local Authority safeguarding contact.

Purpose of the SAR

- SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death, as well as sharing good practice. 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. Other processes exist for that, including criminal and disciplinary procedures, employment law and standards regulated by professional regulatory bodies such as the Care Quality Commission (CQC), the Nursing and Midwifery Council, Social Work England and the Health and Care Professions Council.
- SARs are independent from other investigations that might be occurring, for example by the Police, CQC or Coroner, although they can still take account of the findings of those investigations.

Who is involved in a SAR and what happens?

- Whilst SABs have the statutory responsibility to ensure a SAR is carried out if the critieria is met, they typically (but not always) commission external consultants as reviewers, who have no connection with any of the organisations or personnel involved in the review in order to ensure independence.
- The organisations involved in the care and treatment of the person under review must co-operate with the SAR (section 44(5) Care Act 2014). Typically, these include agencies who are already SAB members, such as adult social care, the police, NHS commissioners and provider services (including the local Integrated Care Board and hospitals), prisons and probation, Housing providers, the Department of Work and Pensions (DWP) and local fire and rescue and ambulance services. However, agencies and providers who do not sit as Board members but had involvement with the individual may be invited to be involved.
- Once the decision has been made to initiate a SAR, the methodology is agreed and a reviewer is appointed. This may be a commissioned independent person external to the SAB member agencies. The SAB has discretion in relation to choice of methodology. Terms of reference (ToR) and/or Key Lines of Enquiry (KLOE) are established, and requests for information including chronologies of events and documentation are sent to the agencies involved. Agencies must comply with requests for information (section 45, Care Act 2014). Sometimes, interviews or learning events are held where all the key individuals involved gather together to discuss what happened in detail. SARs are centred around collecting, collating and analysing facts provided by the agencies involved - it is not an investigation where new information is gathered or created. Finally, the independent reviewer begins writing their report, consulting on and sharing drafts until a final version is agreed. The analysis undertaken and conclusions drawn remain the opinion of the independent reviewer. The agencies involved will normally be asked to confirm the report's factual accuracy. Correction of factual inaccuracies might lead the reviewer to amend their analysis and conclusions. For this reason it is not normal practice to share draft reports until a final version has been accepted by the agencies involved (which acts as confirmation that the factual information upon which the reviewer's opinions have been based is correct) and the report is approved by the SAB.
- The statutory guidance that accompanies the Care Act (2014) (DHSC, 2023) advises that the individual, where they have survived abuse or neglect (including self-neglect), should be invited to contribute to the SAR. In all cases family members and relevant significant others should also be invited to contribute to the SAR, as appropriate, unless there are exceptional reasons to depart from this expectation. Such reasons should be recorded. Involvement might include contributing to the terms of reference or key lines of enquiry,

meeting with the independent reviewer to share observations about practice, and commenting on report drafts.

- The objective is to complete and disseminate learning as soon as possible. The statutory guidance advises as follows. “The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings.” Such reasons should be recorded. Most SARs are completed between 6 and 12 months.
- During the SAR process, ownership of the report remains with the SAB. Information provided for the SAR in the format of choronologies, IMRs (Individual Management Reviews) or any other form of document by an agency belongs to that agency. An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation. The aim of an IMR should be to look openly and critically at individual and organisational practice and at the context within which people were working. Not all SAR methodologies include chronologies and/or IMRs; the format of information requested varies and is an individual SAB decision.
- It is strongly recommended that SABs work with their Local Authority to provide all commissioned independent reviewers with a contract, confidentiality agreement and data processing agreement which sets out the process and ownership when sharing and storing information.
- The statutory guidance that accompanies the Care Act advises that the SAB has discretion regarding the methodology to be used, the time period to be reviewed and whether or not the final report is published either in full or in part.
- Quality Markers have been published by the Social Care Institute for Excellence (SCIE). These are essentially a set of best practice standards for SABs to consider. They cover the entire SAR process, from the point of deciding whether or not to commission a SAR, through decision-making on methodology and family involvement, to discussion of the final report and questions of publication and dissemination.

Section 42 – Adult Safeguarding

- Anyone may refer an adult with care and support needs, who is experiencing or at risk of abuse or neglect (including self-neglect) and who appears unable to protect themselves from that abuse/neglect because of their care and support needs. On receipt of such a referral, the Local Authority must decide whether to conduct an enquiry or cause an enquiry to be made.
- Adult safeguarding enquiries are not normally undertaken where an adult with care and support needs has died, unless there are other individuals potentially or actually at risk. It aims to decide what, if any, action is needed to help and

protect the adult. It will usually start with asking the adult about their view and wishes, which will often determine what next steps to take.

- All those involved in an enquiry must focus on improving the adult's well-being and work together toward that shared aim. At this stage, the local authority also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.

Coronial Processes

- Coroners are independent judicial officers and are either doctors or lawyers, appointed by the Local Authority, with a statutory duty to investigate the cause of certain deaths.
- Coroners have a duty to investigate certain deaths under section 1 of the Coroners and Justice Act (2009) if they have reason to suspect that:

  (a) the deceased died a violent or unnatural death,

  (b) the cause of death is unknown, or

  (c) the deceased died while in custody or otherwise in state detention.

- The purpose of an inquest is not to determine who was responsible for a death and Coroners are unable to consider criminal liability as part of their investigation – there are other processes in place for this, including criminal and civil courts. An inquest is held to determine
  - who died
  - where they died
  - when they died
  - how they came to their death

- Coroners must ensure that the relevant facts are fully and fairly investigated and are subject to public scrutiny during the inquest hearing. Coroners alone are responsible for deciding on the scope of the inquest and the evidence to be called, with the agencies involved contacted directly for information and named individuals required to attend an Inquest and provide evidence. Each inquest is different and the agencies involved and information requested will vary from case to case.

- The coroner must complete an inquest within 6 months of the date on which the coroner is made aware of the death, or as soon as reasonably practicable after that date. There may be various reasons for the Coroner not being able to complete the inquest within this timescale. Where an inquest is not completed within one year of the date on which the death was reported, the Coroner is under a duty to notify the Chief Coroner and provide reasons for the delay.

Case examples

WSAB had commissioned a SAR and notified the coroner. Several agencies involved with both the inquest and the SAR felt that staff could not contribute fully to the SAR whilst the inquest hearing was pending, mainly because they were aware that family members were intending to pursue claims against the services involved. In discussions with the coroner, the agencies involved and family members, it was agreed that the SAR would proceed in two stages. The reviewer would initially consider all available documentary evidence and produce an interim report, which was signed off by the SAB. This would be shared with the coroner and disclosed in inquest proceedings. Following the inquest, the SAR process would resume, with learning events and family involvement, following which a final report would be signed off by the SAB and disclosed to the coroner.

This two-stage process was followed in another case by YSAB when the SAR reviewer was also present at the inquest to answer questions about the interim report.

In one case, involving the death of a young adult, the coroner indicated in their summing up that it would be appropriate for TSAB to consider conducting a SAR. One of the agencies involved subsequently referred the case to the SAB and a review was commissioned and completed. The final report, agreed by the SAB, was sent to the coroner.

Current Legal Guidance

This section covers the following questions raised through the National Survey and Workshops:

- **Which legal powers enable Boards to request information for a SAR?**
- **Which legal powers enable Coroners to request information for an Inquest?**
- **What happens if I'm approached for chronologies that do not belong to me?**
- **What if a draft SAR is requested before it is finished?**
- **What happens if a Board Manager or Chair is named an 'interested party'?**
- **What happens if a SAR reviewer is named an 'interested party'?**
- **Who provides and funds legal representation for Boards and SAR authors?**

Information Sharing

- The SAB has a statutory right to request information (*See Section 45 of the Care Act 2014*). Where this information request is to enable a SAB to complete a statutory duty, the organisation or individual to whom the request is directed must comply.
- The General Data Protection Regulations (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately. Information can be shared without consent where it is lawful to do so and a clear basis for doing so should be recorded.
- There are 7 principles for information sharing: it must be necessary, proportionate, relevant, adequate, accurate, timely and secure. Those involved must ensure that the information shared is necessary for the purpose for which they are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
- Schedule 1 Paragraph 18(1) of the Data Protection Act 2018 has 'safeguarding of children and individuals at risk' as a processing condition that allows practitioners to share information, including without consent (Paragraph 18(1)(c) - where, in the circumstances consent cannot be given, it cannot be reasonably expected that a practitioner obtains consent, or if to gain consent would place a child at risk).
- Relevant personal information can be shared lawfully if it is to keep an adult at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being subject to the conditions of Schedule 1 Paragraph 18(2) and (3) of the Data Protection Act 2018 being met:

> (a) in the circumstances, consent to the processing cannot be given by the data subject;
>
> (b) in the circumstances, the controller cannot reasonably be expected to obtain the consent of the data subject to the processing;
>
> (c) the processing must be carried out without the consent of the data subject because obtaining the consent of the data subject would prejudice the provision of the protection mentioned in sub-paragraph (1)(a).
>
> (3) For the purposes of this paragraph, an individual aged 18 or over is “at risk” if the controller has reasonable cause to suspect that the individual—
>
> (a) has needs for care and support,

(b) is experiencing, or at risk of, neglect or physical, mental or emotional harm, and

(c) as a result of those needs is unable to protect himself or herself against the neglect or harm or the risk of it.

- The Caldicott Principles require that Heath and Social Care practitioners are professionally obliged to comply with those principles when processing personally identifiable information.
- The 8 Caldicott Principles are:

  - Justify the purpose(s) for sharing confidential information
  - To use confidential information only when it is necessary
  - Use the minimum necessary confidential information
  - Access to confidential information should be on a strict need-to-know basis
  - Everyone with access to confidential information should be aware of their responsibilities
  - Comply with the law
  - The duty to share information for individual care is as important as the duty to protect patient confidentiality
  - Inform patients and service users about how their confidential information is shared

- Where an individual is deceased the right to the protections afforded by the statutory frameworks dies with them (Recital 27 of the General Data Protection Regulations 2018). However, living individuals including family members and others involved in the SAR will still have the right to those protections. Further, the Freedom of Information Act 2000 does provide some exceptions to this rule (*see Section 40 personal information and Section 41 confidential information which can include social care and medical records).*

The Coronors and Justice Act (CJA) 2009 paragraph 1(7) gives the Coroner the power to make whatever enquiries are necessary to decide if paragaphs 1(1) and 1(4) arise.

Coroners have the power to call witnesses to appear at an inquest, and to determine the evidence to be heard. It is the general duty of every citizen (under common law) to attend an inquest if they are in possession of any information or evidence that details how a person came to their death.

Notification to appear as a witness will generally be informal, but a Coroner can issue a summons where a witness absents themselves without explanation. Summonses are issued under the Coroner's common law powers and are governed by the directions set out in the Civil Procedure Rules.

Coroner's can issue two types of summonses: requiring attendance to give oral evidence, and requiring attendance to produce documents. All witnesses who are competent can be compelled to attend a Coroner's Court; a person cannot refuse to be a witness because they fear their evidence may lead to them being charged with an offence connected with the death of the deceased. Once sworn in, a witness may refuse to answer any questions put to them on the grounds of self-incrimination (Rule 22 - Coroners (Inquests) Rules 2013).

CJA Schedule 5 now gives coroners the power to require evidence to be given or produced:

- At the inquest by giving evidence and producing any document in the person's custody or under their control relating to a matter relevant to the inquest;
- To provide a written statement during the investigation (previously provision of statements was a voluntary matter);
- To produce any documents or any other thing relevant to the investigation;
- A caveat remains in respect of privileged material that would not be required to be disclosed in civil proceedings;
- Ultimately, there are powers of entry, search and seizure.

To be effective, these powers require the coroner to serve a formal notice that also sets out the consequences of not complying. Obviously, for day-to-day matters, coroners will use an informal approach, at least in the first instance.

There is an opportunity to respond and explain that compliance is not possible or is unreasonable, following which the coroner then makes a decision after considering the importance of the information and the public interest.

Note that a document is in a person's custody whether they are in possession of it or merely have a right to possession of it.

Intentional suppression or concealment of a document believed to be relevant, or its alteration or destruction, can result in criminal sanctions including a fine of up to £1000 or up to 51 weeks in prison.

For these purposes, the definition of relevant is very wide – "if a person conducting an investigation…would (if aware of its existence) wish to be provided with it".

Clearly great care and thoroughness is required when dealing with disclosure issues. Without suitable records evidencing due process, it could be very difficult to prove that an inadvertent non-disclosure wasn't intentional.

In practice, many coroners now routinely request access to medical records for healthcare-related inquests.

SARs are normally published using a pseudonym so that individuals and their families are not identified whereas inquests identify the person. As such there is a need to consider carefully how to manage 'jigsaw or mosaic' disclosure:

https://ico.org.uk/for-organisations/foi/freedom-of-information-and-environmental-information-regulations/information-in-the-public-domain/

It is suggested that SAR's are treated the same way as the other post death reviews that are conducted by other agencies (eg NHS Serious Incident Reviews). In general terms, such reports are not treated as evidence in their own right at inquest, as such reports will often provide findings or make recommendations, both of which rely on the determination of the facts of the case. By virtue of Rule 27 The Coroner's (Inquest) Rules 2013, no person may address the coroner or jury as to the facts of the case, so full reports are not usually adduced in evidence. However, they are frequently used to identify areas of interest or concern, and assist in the identification and formulation of questions for a witness.

Ownership of information

- The General Data Protection Regulations 2018 Article 4(7) and (8) draws a distinction between a 'controller' and a 'processor'. This recognises that not all organisations involved in the processing of personal data have the same degree of responsibility.
- '**controller**' means the natural or legal person, public authority, agency, or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data. The Controller must demonstrate compliance with the General Data Protection Regulations 2018 and make the decisions about how the information is processed and shared.
- '**processor**' means a natural or legal person, public authority, agency or other body which processes personal data on behalf of the controller.
- Legal opinion received when preparing this briefing has advised that SABs will usually act as both Data Controller and joint Data Controller with any authorised partner agencies for the processing of information. Legal opinion received also advised that once a report is published the SAB will be the Data Controller of that report and the information contained therein.
- Information should be held and retained in accordance with the relevant privacy notice and any information sharing agreement held by the relevant parties.
- During the SAR process, ownership of the report lies with the SAB. An independent reviewer should not disclose the report without permission of the SAB. However, where they have been required to give evidence it should be clear that their opinion evidence may be subject to change if further information is uncovered during the Inquest or other parallel investigations.
- Although ownership of the report remains with the SAB, information provided for the SAR by an agency belongs to that agency. Therefore, the relevant agencies would be best placed to provide information to an inquest on the facts contained within any chronology, Individual Management Report (IMR) or any other form of information submitted for a SAR, and the SAR reviewer

would be best placed to provide an opinion on the KLOEs within the SAR ToR.

- SABs can be instructed by the coroner to provide documents relating to an individual which are being held by the Board for the purposes of a SAR. All requests should be discussed initially with the Local Authority legal team. In most cases, sharing a report that has been agreed by the agencies involved as accurate and has been approved by the SAB should be sufficient for the purpose of an inquest. Both SARs and inquests have learning as their purpose and approved reports represent the best evidence available.
- Here, and throughout, where the Local Authority legal team cannot advise the SAB, because of a conflict of interest, the SAB should consider acquiring independent legal advice.
- It is recommended that the SAR is discussed with the coroner at the pre-inquest hearing if possible, as expectations about information required and how this can be provided can be set out at an early stage in line with the Chief Coroner's Law Sheet No. 3. Requests for disclosure of agency IMRs or chronologies should be made directly to those agencies as they remain the data controllers. Depending on the methodology and timescales for the SAR, there can be a number of options for sharing:

  - Sharing the information disclosed to the Board (see above and also below on document ownership)
  - Sharing a draft of the SAR report which has been signed off by each agency as being factually accurate, even if the format, recommendations and learning have not yet been finalised
  - Sharing the completed SAR in full
  - Sharing the learning and recommendations
  - Sharing an executive summary

Onward Disclosure

- Onward disclosure is the disclosure of information to a third party who is not a party to the SAB or an interested party within an inquest at the point the information is shared.
- If possible, unless there is a legal obligation for the onward sharing of information, consent from the relevant party should be obtained in writing to allow onward disclosure. However, if it is not possible to obtain consent and onward disclosure of information is necessary, permission **must** be sought in writing from the relevant partner organisation for the sharing of information outside of their respective domain. Such permission will only be granted where proposed sharing of relevant and proportionate information is within the agreed principles: i.e. for the purposes of safeguarding an Adult at Risk
- The party to whom the data relates should be informed as soon as possible after disclosure to the third party.
- With inquests usually held in public, information disclosed may enter the public domain.

Case Law

Further onward disclosure to a professional body, such as the coroner, would have a lower bar than if the disclosure were to a non-professional body or the public at large (See the Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire refers to disclosure as a two-stage process (a) to the coroner alone; and then (b) for the coroner to decide whether there can and should be onward disclosure:

https://www.judiciary.uk/wp-content/uploads/2015/12/worcestershire-county-council-v-hm-coroner-for-the-county-of-worcestershire-2013-ewhc-1711-qb.pdf

This is important in respect of a decision to share information prior to a SAR being published, or where a decision has been taken not to publish but where the information contained within a SAR may be material to a Coroner's Inquest.

Case example

XSAB was approached by their local coroner who requested copies of all the chronologies submitted for a SAR. The SAB independent chair and coroner had several conversations about the purpose of a SAR and inquest, with the SAB chair indicating why it would not be appropriate to disclose copies of documentation that had been provided to enable completion of the review. It was agreed that the SAR would be disclosed when completed and that the SAB chair and SAR reviewer would be available to give evidence at the Inquest.

Being named an Interested Party

- The CJA 2009 sets out at Paragraph 47(2) who is an interested person:
- "Interested person", in relation to a deceased person or an investigation or inquest under this Part into a person's death, means—

  (a) a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister;

(b) a personal representative of the deceased;

(c) a medical examiner exercising functions in relation to the death of the deceased;

(d) a beneficiary under a policy of insurance issued on the life of the deceased;

(e) the insurer who issued such a policy of insurance;

(f) a person who may by any act or omission have caused or contributed to the death of the deceased, or whose employee or agent may have done so;

(g) in a case where the death may have been caused by—

(i) an injury received in the course of an employment, or

(ii) a disease prescribed under section 108 of the Social Security Contributions and Benefits Act 1992 (c. 4) (benefit in respect of prescribed industrial diseases, etc),

a representative of a trade union of which the deceased was a member at the time of death.

A Local Authority, social worker or similar would fall within the definition given at paragraph 47(2)(f) and by extension, a SAB Chair, SAB Manager or SAR Reviewer could have information (from SAB activity, including previous SARs) that could assist the coroner. The Coroner has discretion to call anyone whom they believe has sufficient interest.

- Interested Persons have important rights during an inquest including:
    - to be notified by the coroner about key aspects of post mortem or toxicology analysis;
    - to be notified of the dates of post mortem and the release of the body;
    - to be notified about the inquest hearing within one week of the date being set;
    - to receive disclosure of documentation held by the coroner and which the coroner considers is relevant to the inquest (subject to certain exceptions);
    - to make submissions to the coroner about key case decisions during the inquest;
    - to question witnesses at the inquest hearing.

- Whether a person is categorised as an interested person is solely at the discretion and decision of the coroner as such a person cannot refuse to

be an interested person if the coroner has deemed that they are an interested person.

- An interested person can choose to represent themselves when attending the Coroners Court or seek formal representation.
- Usually, the local authority legal department would provide legal representation for the SAB Manager/Chair or SAR reviewer; however, Boards can seek their own independent legal advice, usually where the local authority also has an interest in the case and the advice to a SAB could be considered to be prejudiced. This should be determined on a case-by-case basis depending on the nature of the case and whether there might be any potential conflict of interest.

Case Example

ZSAB commissioned a SAR in 2019 with a commissioned independent reviewer. The SAB was subsequently made an interested party and commissioned a barrister to provide legal advice ahead of the inquest. The SAB chair gave evidence at the inquest about the findings of the SAR and progress on implementation of the review's recommendations. All interested parties, including the SAB, were consulted on whether the coroner should issue prevention of future deaths notices to one or more of the services involved.

- There should be an escalation process within the local authority in case someone is called to give evidence and advice should be sought from the local authority legal team in the first instance.
- If a local authority or third party is requested to give evidence before the Coroners Court, then the person providing that evidence must be the person with the first-hand knowledge. This is a common law principle but is also enshrined in statute such as the CJA 2003. SAB chairs, Managers and reviewers would fit into this category if, for example, the purpose is to provide evidence about the commissioning and completion of the SAR, and the outcomes of implementation of SAR recommendations.
- Further any statement provided, to any court, is signed with a statement of truth which confirms that the information contained in the statement is within the person's own knowledge and is accurate and truthful.
- If a SAB chair, manager or SAR Reviewer is called to give evidence, the SAB chair should consult with the local authority lawyer initially. If there is a conflict, then consider securing independent legal advice.
- Pre-inquest hearings will determine the nature of the evidence to be given by SAB chairs, managers or reviewers. Their evidence will be about decision-making regarding commissioning and completion.

Case Law Example

All witnesses who are competent can be compelled to attend a Coroners Court; a person cannot refuse to be a witness because they simply do not wish to be or because they fear their evidence may lead to them being charged with an offence connected with the death of the deceased or may have consequences for their organisation or profession (including professional conduct). (Coroners and Justice Act 2009 Schedule 5 Paragraph 1.) (see HMRC v HM Senior Coroner for Liverpool:- https://www.judiciary.uk/wp-content/uploads/2015/12/r-commissioners-for-hmrc-v-hm-coroner-for-city-of-liverpool-2014-ewhc-1586-admin.pdf

- The coroner can issue a summons to request your attendance as a witness at the inquest. If you receive a summons, you must act on any instructions provided as soon as possible. If you are unable to attend the inquest on the date and time stated, you should contact the Coroner's Office immediately.
  - Failure to attend could result in the coroner issuing a warrant and you will be arrested and brought to court and could, in a worst-case scenario, be charged with contempt of court which may result in up to 51 weeks imprisonment and/or a fine (CJA 2009 Schedule 5 Paragraph 6).
  - The coroner does have discretion to allow evidence to be provided by written statement alone subject to the criteria as set out in The Coroners (Inquest) Rules 2013 Rule 23 which states:

23. (1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the coroner is satisfied that—

(a)it is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;

(b)there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;

(c)there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or

(d)the written evidence (including evidence in admission form) is unlikely to be disputed.

(2) Before admitting such written evidence the coroner must announce at the inquest hearing—

(a)what the nature of the written evidence to be admitted is;

(b)the full name of the maker of the written evidence to be admitted in evidence;

(c)that any interested person may object to the admission of any such written evidence; and

(d)that any interested person is entitled to see a copy of any written evidence if he or she so wishes.

- Any witness however is not obligated to answer any question which may incriminate them and if the coroner is minded that a question, if answered, may have that outcome they in turn must inform the witness that they may refuse to answer (CJA 2009 Rule 22)

Disclosure by coroners to interested persons

Part 3 (paragraphs 12-16) of the Inquest Rules deals with disclosure by the coroner to other interested persons. The onus is on interested persons to request disclosure, and of course they won't always know what the coroner holds – although in reality blanket requests are usually made by experienced advisors.

The starting point is that the coroner must disclose relevant (in the coroner's opinion) documents upon request as soon as is reasonably practicable.

Examples specifically mentioned in the Rules are post mortem examination reports, other reports provided to the coroner during the investigation, and any other document the coroner considers relevant to the inquest (which clearly may include the deceased's medical records).

Disclosure may be by electronic copy and redaction may be undertaken. Alternatively, the document may be made available for inspection.

Rule 15 provides some restrictions on disclosure in that the coroner may refuse where:

- There is a statutory or legal prohibition on disclosure (which may cover privileged material shared only with the coroner)
- The consent of any author or copyright owner cannot reasonably be obtained
- The request is unreasonable
- The document relates to contemplated or commenced criminal proceedings or the coroner considers it irrelevant to the investigation
- As a change to the old rule, the coroner may no longer charge a fee for disclosing documents to interested persons before or during an inquest

General Points

- Processes can run concurrently and are not co-dependent or sequential – there is no statutory guidance instructing that one should take place before the other. In some cases, there may be benefits to an inquest going ahead first, and in others there may be benefits to a SAR going ahead first. To assist with local decision making we have included a section on factors to consider before deciding locally (**see 'Timescales'**) There are no rules, either in statute or guidance, on whether a SAR or a coroners inquest should take place before the other one.
- In the normal course of events an inquest would not be delayed purely because a post death review was waiting to be completed, although such decisions are made on a case-by-case basis.
- It may be that any decision on which process goes ahead first or is finalised first will need to be considered on the basis of the benefits and disadvantages of any course of action on a case-by-case basis.
- If the SAR is finalised first then it is likely that the report will become part of the coroner's inquest evidence, if the SAR report is not yet finalised it would be reasonable to discuss how to proceed with the coroner since, as it is not a completed document, it might be altered as a result of the conclusions made at the inquest and/or further information collection and analysis for the SAR.
- Whilst those giving evidence to the SAB may be offering opinion and analysis alongside factual information, as the parties should be working together to learn and develop practice and service improvement strategies, the fact that any finalised report may then go to the Coroners Court should not deter the parties from working transparently and collaboratively, as fear of the court or the public

at large making assumptions that are incorrect would not be founded as the report is usually, but not always, published and often anonymised.

Case Examples

ZSAB commissioned a SAR in 2021 with a commissioned independent reviewer. The Coroner was aware of the SAR and requested the draft report to consider as part of the inquest. The draft report was provided, but subsequent drafts and the final report contained significant differences meaning inaccurate information was considered for the Inquest.

QSAB commissioned and completed a SAR that featured resident on resident abuse. The case received significant media attention. The SAB was aware that an Article 2 inquest* was to be held and informed the coroner that a SAR had been completed. The SAB was recorded as an interested party and the SAR report was disclosed to the coroner and other interested parties. The SAB chair and SAR reviewer both gave evidence at the inquest about how the review had been conducted, its findings and recommendations.

Definition – Article 2 Inquest

Article 2 ECHR imposes a general duty on the state to set up a judicial system that allows for an independent, practical and effective investigation into the facts of any death. If a person has died whilst under the care or protection of the state, or whilst in state custody, an Article 2 inquest will take place. Examples include where someone has died in immigration detention, in prison, or in police custody.

An Article 2 inquest might also be held when the state or a private body is implicated in a death. Examples include where a person has died following a police chase; if military authorities do not provide adequate equipment to a soldier, or if hospital staff fail to recognise a person's immediate and real risk of suicide leading to their death.

Finally, Article 2 can also apply if systemic or policy-based failures have caused a person's death, such as where a person has died due to unsafe hospital policies.

An Article 2 Inquest means that the state have to carry out an 'enhanced investigation' into the death. Whereas a 'traditional', non-Article 2 inquest will look at

when, where, and how a person died, an Article 2 Inquest also looks at the wider circumstances surrounding a person's death.

This means that an Article 2 inquest can be more detailed and may well consider issues which would otherwise be deemed to fall outside of the scope of a non-Article 2 inquest. Article 2 inquests can also qualify for additional funding which would otherwise not be available.

The following sections cover areas where there is currently no legal guidance and are therefore recommendations for best practice.

Notification Process

This section covers the following questions raised through the National Survey and Workshops:

- **Are SABs required to inform a coroner of a SAR?**
- **Should coroners be informed when a referral is received or when a SAR is commissioned?**
- **What information should be shared with the coroner?**

Establishing contact with the coroner at an early stage is recommended. However, this is a local decision. There can be positive benefits from having an established open route of communication at an early stage:

- Reducing distress for bereaved family members
- Joined up approach increases awareness of other processes that may feed into a SAR or inquest
- Information about the SAR and inquest will go to the right person in a timely manner
- Consideration of both processes and adjusting timescales where needed, reducing delays
- Providing information about what a SAR may look like, the purpose and timescales will help manage expectations

To assist with establishing communication, a template email and form have been developed which can be adopted locally:

- Template email to inform the coroner of a referral for a SAR. It can be useful to inform of cases under consideration, however this must be a local decision (Appendix 1)
- Template email to inform the coroner a SAR is being commenced (minimal information) (Appendix 2)
- A template form to inform the coroner a SAR is being commenced (extended information and request for inquest information) (Appendix 3)
- It is recommended that when informing the coroner of a SAR, you also send over a short guide to SARs which can help set out the purpose, process and local referral route. If you do not have a local short guide, you will find some examples in Appendix 4 which you can adapt and use locally.

Timescales

This section covers the following questions raised through the National Survey and Workshops:

- **Which should be completed first – the SAR or the Inquest?**
- **What are the benefits of a SAR being completed before an Inquest?**
- **What are the benefits of an Inquest being completed before a SAR?**
- **How do we decide and who makes that decision?**

As SARs and inquests can run concurrently, consider the following points when making your decision locally:

- If an inquest is completed first, this can provide a cause of death that will support with decision making about whether SAR criteria are met
- The SAR process can take a significant amount of time to complete. As a final version needs to be signed off by both the multi-agency SAR Panel/Subgroup and then the main multi-agency SAB, it is not possible to definitively determine a completion date – this could mean an inquest being delayed if it was felt the SAR needed to be completed first
- In some cases, the independent reviewer may be given permission to view or receive the evidential bundle for the inquest and/or attend the inquest (for example with a SAR completed by Norfolk SAB), which can be useful in finalising a SAR report. However, receipt of information and attendance at the inquest is at the discretion of the coroner. Facts contained in the bundle cannot be used, included or published without express permission from the coroner.
- If a SAR is commenced first, agencies can be reluctant to reflect openly on their practice to support learning as this information may be considered in an inquest
- Early drafts of SARs can differ greatly from final versions and are highly likely to contain inaccurate information, so only a final version will contain information that can meaningfully contribute to an inquest
- Learning from a SAR can be pulled into a Regulation 28 notice if completed first; alternatively, it may evidence that learning and actions have already been completed, negating the need for a Regulation 28 notice.
- Completing a SAR before an inquest can mean the SAR is written as a piece of evidence to be used at an inquest and centres on the activity of individuals and individual agencies, rather than a strategic focus on systemwide learning
- There can be challenges in accessing information for a SAR, information that may be available for an inquest

Being cognisant of these potential impacts, it is advisable to agree timescales locally on a case-by-case basis where possible.

Publication

This section covers the following questions raised through the National Survey and Workshops:

- **When should a SAR be published and how is this decision made?**
- **Can/should publication be delayed due to an inquest?**
- **What about thematic reviews where they relate to more than one individual?**

- The decision about if and when a SAR should be published is a SAB decision. Although it is not a statutory or professional obligation, there is a presumption that the SAB will publish unless there is a good reason not to. The Care Act (2014) statutory guidance states that '14.179 - In the interest of transparency and disseminating learning the SAB should consider publishing the reports within the legal parameters about confidentiality'. Publication provides an opportunity to share learning and allows SABs to be open and transparent about the recommendations.
- In the majority of cases the SAR report is published unless there is good reason not to do so which may include matters such as consideration of the impact on the family, timing with other processes such as the coroners court, and safety and wellbeing of those involved. Each matter will need to be considered on its own merits.
- Once a report is in the public domain and may be reproduced in the press or online, this may also lead to press interest and requests for further information. Any such request must be considered very carefully as any additional information provided may breach GDPR or be detrimental to other ongoing processes or court hearings.
- Reports can be published as an abridged version, an executive summary, if this is deemed to be appropriate on a case-by-case basis.
- The coroner can request that publication is postponed until an Inquest is completed and SAB would be expected to comply with this request.

As stated above there is no statutory or professional obligation to publish a report, although the Care Act (2014) statutory guidance strongly suggests that SABs should consider publishing in the interests of learning and transparency and that the SAR should be completed as soon as possible, ideally within 6 months. However, it is noted that the SAR report can be withheld until such time as the inquest has been completed. There are both legal and practical reasons for doing so, publication may:

- Influence a jury's decision.
- Influence acting Counsel or witnesses and fetter discretion, decision making, or evidence.

- Result in the report needing to be amended once the inquest outcome is known causing distress to those involved.

- Thematic reviews will include information about more than one individual so publication may depend on the content of all of these cases. If a thematic review is published, the decision maker will need to check that all the information in the document is already in the public domain in relation to reference to previous SARs and the names of parties contained therein. If reference is made to a matter not previously in the public domain, then it would not potentially be reasonable to now place that information in the public domain. In this case, it is suggested that the coroner would initially need to see the entire SAR so that there can be discussion about redaction of material relating to individuals whose cases are not the subject of an inquest before disclosure to the parties at the inquest.
- There is an option to publish the report without placing that information into the public domain such as anonymising the published information by redaction or removal of the names, but consideration will need to be given to whether the other information would identify the parties.

Regulation 28

- The CJA 2009 grants Coroners the power to issue Regulation 28 Prevention of Future Deaths notices to an individual, organisation, Local Authorities or government departments and their agencies, where the coroner believes that action should be taken to prevent future deaths. By definition, this could include a SAB.
- Organisations to whom Regulation 28 notices are delivered have 56 days to respond with the actions they have taken or will take to comply with a Regulation 28 notice.
- SABs along with other interested parties might be requested by a coroner to provide a submission as to whether Regulation 28 notices should be issued. Legal advice should be sought here.
- SABs should be working with their local coroner to receive any Regulation 28 Notices issued within their area that may relate to adults with care and support needs, safeguarding or quality of service, and should be requesting assurance from the agencies named.

Recommendations

The following best practice recommendations should support joint working between coroners and SABs:

- SABs should establish a Single Point of Contact at their Coroner's office

- SABs and coroners should look to develop a local joint working protocol (this guidance can be used as starting point)
- Use the templates in the accompanying toolkit to ensure good information sharing
- IMR and chronology requests should include a caveat that states the information may be disclosed, if required, by the coroner
- SABs should have a contract in place with any commissioned independent reviewer which sets out details of information governance and includes that reviewers may be required to attend Coroner's court, as well as supporting documents such as confidentiality agreements and data processing agreement. This should be developed with the local authority.
- SABs should ensure that they have confidence in decision making around SARs and have documents in place to record the decisions and rationale so as to be able to provide reassurance that a SAR is /is not required when challenged
- Ensure your local coroner is aware they can make referrals for SARs and provide a referral form
- Consider support for individuals and their families who are subjects of SARs (consider Healthwatch, advocacy service or the voluntary and community sector)
- Ensure commissioned SAR reviewers are sighted on any local protocol or working agreement between coroners and SAB
- Boards should consider adding a statement to their constitution, scoping templates and information sharing guidance that information may be shared with the coroner for purposes of an inquest.
- Boards may wish to consider updating their SAB Chair and SAB manager specifications/job decsriptions to include that attending Coroner's court may be required as part of their role.

Suggestions for Use

This best practice guidance has been developed for both SABs and Coroners, and can be utilised in the following ways:

- As a starting point to support with developing a local or regional joint working document
- The content can be incorporated into local SAB Learning and Review Frameworks
- The content can be incorporated into local existing training, or can be developed into a short webinar/podcast/e-learning which can be part of local training

We would also recommend that SABs make reference within their Constitution, SAR Scoping Templates and Information Sharing Agreements that information may be shared with the Coroner for the purposes of an inquest.

Appendices

- **Appendix 1 – Template email to Coroner informing them of a SAR Referral**
- **Appendix 2 – Template email to Coroner informing them a SAR is being commenced (short version)**
- **Appendix 3 – Form to inform Coroner a SAR is being commenced (extended version)**
- **Appendix 4 – Examples of Short Guides to SARs**

Appendix 1 – Template Email to Coroner informing them of a SAR referral

Dear_____,

X Safeguarding Adults Board has received a referral for a Safeguarding Adults Review under Section 44 of the Care Act (2014) for the following individual:

Name:

Address:

Date of birth:

Date of death:

Appendix 2 – Template Email to Coroner informing them a SAR is being commenced

Dear_____,

X Safeguarding Adults Board have commenced a Safeguarding Adults Review under Section 44 of the Care Act (2041) for the following individual:

Name:

Address:

Date of birth:

Date of death:

Appendix 3 – Notification of a Safeguarding Adults Review

[Add SAB logo]

Notification of a Safeguarding Adults Review

This form is to notify the [add area] Coroner that a Safeguarding Adults Review (SAR) has been commenced by the [add SAB name] Safeguarding Adults Board. Accompanying this form, you will find a short guide to SARs which sets out the legal framework, purpose and process for SARs which you may find useful.

Although SARs and Inquests are separate processes, it is recommended good practice to establish communication. As such, this form is also to request information about any inquest that may be taking place.

1. Lead for the Safeguarding Adults Review	
Safeguarding Adults Board	
Contact for all correspondence (e.g. SAB Manager, SAR Coordinator, SAR Panel Chair) – please include name and contact details	
2. Details of the deceased	
Name	
Date of Birth	
Date of Death	
Address	
3. Safeguarding Adults Review details	
Mandatory or discretionary SAR	
Date of decision	
Family informed	
Agencies involved	
Independent reviewer (yes/no)	
If yes, have they been appointed?	
Methodology (will there be a written report/workshop with slides/outcomes or recommendations)	
Estimated time for completion (please note this is a guide and there are may variables which can impact this)	
4. Inquest	
Has it been confirmed there will be an inquest?	

Estimated timescale for inquest	
Name and contact details of contact for all correspondence relating to the inquest	

Appendix 4 – Example of Short Guides to SARs

Bromley Safeguarding Adults Board

Salford Safeguarding Adults Board

Nottingham City and Nottinghamshire County Safeguarding Adults Board joint guide

Essex Safeguarding Adults Board