**Sussex   
Adult Death Protocol**

| **Document properties** | **Version details** |
| --- | --- |
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| Document owners | Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards |
| Version | 1 |
| Review plan | The protocol will be reviewed by representatives nominated by the Brighton & Hove, East Sussex and West Sussex SABs on an annual basis. |
| Review date | May 2021 |

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# Foreword by Graham Bartlett and Annie Callanan, Independent Chairs of the East Sussex, Brighton and Hove and West Sussex Safeguarding Adults Boards

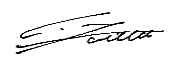
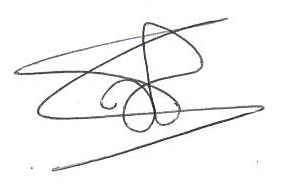
The East Sussex, Brighton and Hove and West Sussex Safeguarding Adults Boards (SABs) are resolute in assuring and developing the way in which agencies work together to protect those at risk from abuse and neglect. Through audit, Safeguarding Adults Reviews and scrutinising the safeguarding system, we share good practice and highlight where things have, or may, go wrong.

Despite this, sadly and tragically, sometimes, vulnerable people do experience abuse and/or neglect which causes or contributes to their passing. When this happens, we, crucially family and, the public expect agencies to collaborate without delay to establish what has happened, whether any crime has been committed and whether there are others at risk who need safeguarding.

Our learning from cases of this kind, is that existing inter-agency systems have not been best equipped to respond in the timely and collaborative approach required. In response, we have together, invested with Sussex Police leading, in the development of a pan-Sussex multi-agency protocol to address this important area.

We are now delighted to introduce the result of the joint efforts of the adult partnership across Sussex agencies who have contributed with great enthusiasm and commitment to creating, this pan-Sussex Adult Death Protocol. It is clear and pragmatic in how it brings key agencies together in the early investigation phase which, we know from experience, is critical in all safeguarding enquiries. The protocol will essentially also, help staff, in these difficult situations and significantly, help assure and support families who, are at the forefront of all that we do.

As with any protocol published by the SABs, we will keep this under review to ensure it is effectively adopted and its objective of achieving effective multi-agency working, to identify potential criminal offences and protect others from abuse or neglect, is met.

**Graham Bartlett, Independent Chair Annie Callanan, Independent Chair**

Brighton & Hove and East Sussex SABs West Sussex SAB

# Foreword by Jayne Dando,

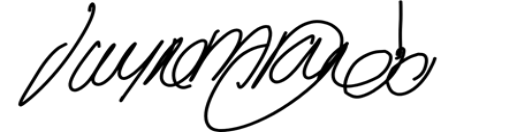
# Assistant Chief Constable, Sussex Police

In 2018 – 2019 NHS Digital collated data from all 152 local authorities in England. Over 400,000 safeguarding concerns were raised nationally in relation to vulnerable adults.  This figure is growing exponentially year on year with eight out of ten vulnerable people falling victim to fraud or suffering abuse or neglect by a person who is responsible for their care.

The Police and partner agencies not only have a duty under the Care Act 2014, but a moral duty to safeguard any adult who is less able to protect themselves from harm and enable people to live without fear in a stable and secure environment. The Care Act 2014 imposes certain obligations on the Police and others to safeguard any adult. One of our key priorities is to protect the vulnerable and we have a responsibility to train our officers and staff on how to recognise signs of abuse and neglect and take action to prevent it from occurring and stop it from reoccurring. The impact of us getting it wrong is catastrophic for victims, their families and potential future victims. This is why, working alongside partners, Sussex Police is pleased to welcome the Sussex Adult Death Protocol. It brings those organisations with safeguarding responsibilities together in order to:

* Share information quickly and efficiently.
* Decide on the most appropriate agency to lead any subsequent investigation.
* Recognise any other vulnerable child or adult that may need safeguarding as a result of this protocol being enacted.
* Identify any organisational learning to improve safeguarding process across all partnerships to prevent others coming to harm.

This protocol has been widely consulted across Health, Local Authorities and the Senior Coroner to ensure where suspicions regarding abuse and neglect are a contributory factor in the death of an adult, that all information and evidence is seized and retained to ensure a thorough investigation in to causes of the death is conducted.  Moving forward we will look to continue to share this and any future learning with other agencies and police forces across the UK to improve safeguarding arrangements for vulnerable adults.



**Jayne Dando**

**Assistant Chief Constable**

# Introduction and purpose of protocol

The circumstances in which an unexpected adult death takes place, where there is a suspicion or it is known that abuse or neglect was involved, can be challenging and complex to navigate with partner agencies having different roles and responsibilities in response to the death.

The joint work undertaken to develop this protocol by the Safeguarding Adults Boards (SABs) across Brighton & Hove, East Sussex and West Sussex reflects a commitment to effective partnership working and information sharing across Sussex and to ensuring a rapid, coordinated response to unexpected adult deaths involving abuse and neglect.

The adult death protocol provides a framework for establishing an agreed standard between partners to:

* Ensure an effective and consistent multi-agency response that will support agencies of the Sussex SABs to meet the requirements of legislation, national and local guidance and practice standards around appropriate responses to unexpected adult deaths involving abuse and neglect.
* Ensure clarity and consistency of procedures across organisations of the Sussex SABs.
* Develop arrangements that support efficiency in partnership working to identify potential criminal offences or when there is a need to conduct investigations into unexpected adult deaths.
* Focus on a commitment to effective information sharing which can lead to improved outcomes in relation to investigating unexpected deaths.

This protocol is based on existing legal mandates and has drawn as appropriate on the current child death review process. It should be used in conjunction with the [Sussex Safeguarding Adults Policy and Procedures](http://sussexsafeguardingadults.procedures.org.uk/) and the [Sussex Information Sharing Guide and Protocol](https://www.eastsussexsab.org.uk/wp-content/uploads/2020/08/Sussex-Information-Sharing-Guide-and-Protocol-v1.pdf).

# Scope and criteria

This protocol is for adoption, information and application by the partner agencies of the Brighton & Hove, East Sussex and West Sussex SABs who are listed at Appendix 1.

The adult death protocol applies to the following criteria:

* an adult dies in unexpected or unnatural circumstances, and
* there is a suspicion, or it is known, that abuse or neglect was a contributory factor in their death, and
* the abuse or neglect was caused by a third party.

For the purposes of this protocol the definition used for an adult is as is set out in [Sections 42 to 47 of the Care Act](https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted) which sets out the legal duties and responsibilities in relation to adult safeguarding. These apply to an adult who:

* has needs for care and support (whether or not the local authority is meeting any of those needs),
* is experiencing, or is at risk of, abuse or neglect,
* as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Given that the protocol only relates to situations in which it is known or suspected that abuse or neglect was caused by a third party, it does not include cases relating to:

* drug-related deaths,
* self-neglect,
* suicide.

Furthermore, any situation involving a suspected homicide will not be covered by this protocol, and the homicide investigation and Domestic Homicide Review process takes precedence.

The protocol does not replace any internal policies and procedures of partner agencies. Staff should also refer to relevant policies and guidance of their own organisation in conjunction with this document.

# Raising a referral for the adult death protocol

When an adult dies and there is a concern that abuse or neglect could be a contributory factor, the agencies with immediate primary responsibility are the police and coroner. Coroners are independent judicial officers who are responsible for investigating violent, unnatural or unexplained deaths. The police response will depend on which criminal offences are suspected and on other factors such as whether anyone else is considered to be at immediate risk of harm.

Given the primacy of the police being contacted in the event of an unexpected adult death, the police will lead on reviewing and triaging any information submitted by an agency about an unexpected adult death to confirm whether the adult death protocol should be used.

Any agency or professional can make a referral for the adult death protocol by contacting the Sussex Police contact centre on 101. The contact centre will record referral details and undertake an initial triage to identify if the criteria for the use of the adult death protocol are met.

These details will then be passed to first line police responders who will visit the location of the body with an ambulance crew. If the Detective Sergeant at the scene assesses that the adult death protocol criteria are met, the details are passed on to the Multi-Agency Safeguarding Hub (MASH) who will set up an Initial Joint Agency Meeting (IJAM) within 24 hours. Further details of this process are set out within the flowchart on the next page.

# Flowchart – overview of adult death protocol (ADP)

Flowchart – overview of adult death protocol (ADP) 

Immediate actions
1 - Unexpected adult death in which ADP criteria are identified by an agency 

The identifying agency contacts Sussex Police Contact Centre via 101 to make a referral for the ADP to be triggered.
The contact centre conducts initial triage to identify if ADP criteria are met.
The contact centre notifies first line police responders to attend location of body.

2 -  Ambulance and Police attend location of the body 
Health professional / clinician confirms death.
First line responders draw on professional judgement and use ADP aide memoir.  If they suspect abuse or neglect by a third party, a Detective Sergeant (DS) attends and conducts initial investigative assessment.
If DS believes ADP criteria are met, a Detective Inspector (DI), Crime Scene Investigators (CSI) and the Coroners Officer attend and conduct a joint examination of the body with the attending medical practitioner. 
Consider safeguarding risk to other adults and raise a safeguarding concern if required.
Engage staff / family and explain ADP process.
If a homicide is suspected, then the homicide process takes primacy.

3 -  Attending DI notifies MASH DI to arrange Initial Joint Agency Meeting (IJAM) 
IJAM to have representation from statutory partners i.e.
Police, NHS Clinical Commissioning Group Safeguarding Team and Adult Social Care,
and any other agency by invitation as required. 

Within 24 hours
IJAM chaired by MASH DI 
Initial information sharing, risk assessment, action plan (including consideration of risk to other adults / children).
DI and health practitioner / clinician confirms case meets ADP.
Confirm lead agency.
Consider involvement from any other relevant agency and plan to request additional information.
Confirm other enquiry / investigation processes.


## Flowchart – overview of adult death protocol (ADP) continued. Within 6 weeks 1 - Police - Investigation into potential criminal offences. 2 - Coroner - Preliminary and final post-mortem examination report provided to the coroner and with coroner’s agreement to the police. 3 - Any other enquiry or investigatory process - Review of health and social care information. Actions undertaken following meeting: Agencies follow own internal processes to review the circumstances of the death. Appropriate feedback of outcomes of local case discussion to family and interested parties. 4 - Follow up meeting to be arranged by lead agency if appropriate to include: Learning from the case. Confirm any further case management actions. Strategic recommendations. Note: Any recommendations made at this meeting are the responsibility of the owning agency to progress.

# Legal considerations

There is a range of legislative frameworks and investigatory processes that may need to run concurrently with any criminal investigation.

[Sections 42 to 47 of the Care Act 2014](https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted) set out a clear legal framework for adult safeguarding and are supported by the [care and support statutory guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance).

A referral for a Safeguarding Adults Review (SAR) may be appropriate where there are concerns that an adult has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. A SAR is concerned with ensuring learning and improvements in practice and is not about apportioning blame. The [Sussex SAR Protocol](https://www.eastsussexsab.org.uk/documents/sussex-sar-protocol/) sets out the approach to undertaking SARs across Sussex that follows both statutory guidance and local policies.

The Sussex Safeguarding Adults Policy and Procedures contains guidance around the [interface between the safeguarding adults process and other investigations and reviews](http://sussexsafeguardingadults.procedures.org.uk/pkotz/sussex-safeguarding-adults-procedures/receiving-concerns-and-undertaking-enquiries#s2798), including:

* Serious Incident Investigations
* Child protection and safeguarding procedures
* Learning Disabilities Mortality Review (LeDeR) Programme
* Safeguarding Adults Reviews (SARs)

In situations where a crime has been, or may have been, committed it is important that any forensic evidence is preserved wherever possible. Further information on this is covered within [chapter 2.4 of the Sussex Safeguarding Adults Policy and Procedures: Safeguarding and Criminal Investigations](http://sussexsafeguardingadults.procedures.org.uk/pkoth/sussex-safeguarding-adults-procedures/safeguarding-and-criminal-investigations).

# Effective multi-agency working

Given the complex nature of responding to situations involving an unexpected adult death, a co-ordinated multi-agency approach is essential to ensure effective information sharing and communication, a shared responsibility for assessing risks and agreeing an action plan.

The Sussex adult death protocol adheres to the principles set out in the [Sussex information sharing guide and protocol](https://www.eastsussexsab.org.uk/wp-content/uploads/2020/08/Sussex-Information-Sharing-Guide-and-Protocol-v1.pdf).

# Working with families

When an adult dies unexpectedly and in suspicious circumstances, effective and appropriate communication with families is of the upmost importance and should be carried out in a respectful and sensitive manner.

In the vast majority of cases where someone dies unexpectedly, nothing unlawful has taken place. It must also be acknowledged, however, that in a small percentage of situations something unlawful may have taken place. This must not be forgotten. Safeguarding adults is everyone’s responsibility.

Providing support and care to the bereaved family from the earliest possible stage is a core component of the joint agency response and runs through all stages of the response. It is likely that the family of the deceased will be distressed and shocked. At all times consideration should be given to the family’s wishes and beliefs, and how these can be accommodated within any statutory requirements. It is every family’s right to have their loved one’s death properly investigated. Families desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented.

In the initial stages following the identification of an unexpected adult death, the police and coroner’s officer will be the main point of contact for family members. At the Initial Joint Agency Meeting (IJAM), responsibility as to which lead agency should provide ongoing information and coordinate appropriate care and support for the family will be confirmed.

Key considerations include:

* It is important to clearly explain the process and what is happening to family members, and provide facilities to contact friends, other family members and cultural or religious support.
* Professionals should express empathy with the family and respectfully use the deceased’s name and correct gender in all conversations. Sharing our humanity can make a real difference to families.
* Consideration should be given to the capacity of the family to engage in the processes unfolding around them. Support from advocacy services should be considered where appropriate. Particular consideration should be given to issues of language, health or mental capacity. Further consideration must also be given to the faith and culture of the deceased and their family.
* Where English is not the family’s first language, every attempt should be made to provide a translation or interpreting service, including out-of-hours provision, for example through Language Line. Family members, particularly children, should not act as interpreters.
* Responsibility for providing ongoing information and coordinating appropriate care and support for the family is shared between the lead health or social care professional, police investigator and coroner’s officer. There needs to be clear liaison between these professionals as to who will take responsibility for each aspect of care and support.
* The family should be told at an early stage that, because their loved one’s death was unexpected, the coroner will need to be informed and there will need to be a police investigation. This must be explained to the family in a sensitive way, emphasising that these are routine procedures that are followed for an unexpected adult death.
* The purpose and process of the joint agency response should be explained to the family, emphasising that all professionals are working together to try to help them understand why their loved one has died and to support them.

The family should be informed that, as part of this process, information will be shared with their primary care team, social services and other relevant professionals.

* The family should be informed that the coroner is likely to order a post-mortem examination. The family should be informed about the post-mortem examination, including the likely venue and timing, any arrangements for moving their loved one, and the likelihood that tissues will be retained during the post-mortem examination. This information should be provided in a sensitive and meaningful manner. As part of the explanation about the post-mortem examination given to the family, the lead health or social care professional or coroner’s officer should explain that tissue samples will be taken and that, following the coroner’s investigation, the family can then determine the fate of the tissue according to the [Human Tissue Act 2004](https://www.legislation.gov.uk/ukpga/2004/30/contents).

The family should be made aware that it may take several weeks to secure the results of the post-mortem examination and for the coroner to come to a conclusion. Every effort should be made to keep the family informed at each stage of the process. The family should receive regular telephone calls from either the health or social care professional supporting the family or the coroner’s office to let them know how matters are proceeding.

* The family should be clearly informed of the names and contact details of the lead professionals responsible for the joint agency response, including the lead health or social care professional, police investigator and coroner’s officer. If it becomes necessary to transfer responsibilities between professionals, the family should be informed of this and introduced to any new professionals involved.
* The family must be given clear details of whom to contact, both in working hours and out-of-hours, should they have any questions or concerns.
* Under the [Police and Criminal Evidence Act 1984, section 29](https://www.legislation.gov.uk/ukpga/1984/60/section/29/enacted), if the police investigator has suspicions that the death may be a crime, the law demands that the suspect’s rights are protected and certain legal restrictions apply in terms of how they can be spoken to, and by whom. This is particularly relevant where the possible suspect is a family member.

# Initial joint agency meeting (IJAM)

The IJAM is a crucial step within the adult death protocol to provide a clear pathway to ensure the effective co-ordination between statutory partners and other relevant agencies involved.

The objectives of the IJAM are to:

* Ensure rapid information sharing and risk assessment (including risk to others).
* Confirm who will be the lead agency.
* Consider any other agencies involved and request information from them.
* Consider any other relevant enquiry or investigatory process and the timing of the same, including further police investigations, Section 42 safeguarding enquiry, Serious Incident Review, Learning Disabilities Mortality Review (LeDeR), Safeguarding Adults Review (SAR).
* Considerations around family members and carers, including views of others and how family or carers will be kept informed.
* Develop a multi-agency action plan with agreed timescales and details of who is leading on each action.
* Consider actions required regarding a media strategy.
* Confirm a communications strategy across senior agency representatives.

The IJAM will be set up via the Multi-Agency Safeguarding Hub (MASH) Detective Inspector (DI), who will liaise with the safeguarding leads for Adult Social Care (ASC) and the NHS Clinical Commissioning Group (CCG) in the relevant area to agree attendees. As a minimum there should always be representation from the three statutory partners. The NHS CCG will attend the initial IJAM and identify and delegate actions thereafter to the appropriate health provider organisations. Similarly, the senior manager representative from ASC at the IJAM will identify and delegate follow-up actions as required to the relevant operational team. Additional agency representatives should be considered on a case-by-case basis. All agencies have a responsibility to attend. Where an individual cannot attend, they should inform the MASH DI and arrange for a representative of a suitable level of seniority from their organisation to attend.

Invitations and documentation for the meeting will be sent securely ahead of the meeting. Attendees should be familiar with their responsibilities and ensure they read all relevant material in advance of the IJAM. Statutory partners should ensure that appropriate information and intelligence gathering is conducted at the outset so that salient information can be shared at the meeting.

The IJAM should take place within 24 hours wherever possible. If the unexpected death is reported over a weekend or bank holiday the IJAM should be convened on the next working day.

The IJAM can be at a physical location or arranged virtually, for example via Skype or MS Teams. The use of remote conferencing should be considered to facilitate optimum attendance. The MASH will provide full administrative support to the meeting, including recording of minutes. The MASH DI will chair the meeting and minutes will be shared with all attendees. Notes of the meeting should be sent to all those in attendance, as well as those core members who may have been unable to attend.

# Follow-up meeting

The requirement to convene a follow-up meeting as part of this protocol should be considered at the IJAM to ensure that actions are monitored and reviewed and to consider any learning from the case. Any follow-up meeting should be convened within six weeks of the IJAM and will be chaired by the lead agency.

The follow-up meeting will involve not only consideration of further case-specific actions but broader systemic learning that may require strategic actions. In considering these recommendations, any agency which is identified to take forward an action will be responsible for progressing that work and for the respective governance and oversight attached to that action.

# Complaints or disputes

Any complaint or dispute arising during the process of the adult death protocol will be dealt with according to the lead agency’s complaints policy. For disputes in relation to health actions, this may well not be the NHS CCG but the appropriate health provider organisation identified at the IJAM.

# Review of this protocol

An initial evaluation of this protocol will take place after six months and 12 months to ensure it meets the objectives of the SAR recommendation.

The protocol will be reviewed by representative(s) nominated by the Brighton & Hove, East Sussex and West Sussex SABs on an annual basis and will also be reviewed in the event of any relevant change in law (with advice being taken as necessary), or changes in the circumstances relevant to the agreement.

# Appendix 1: Parties to this protocol

**Partners of the Brighton & Hove SAB**

* Brighton & Hove Health and Adult Social Care
* NHS Brighton and Hove Clinical Commissioning Group
* Sussex Police
* Age UK Brighton & Hove
* Brighton and Hove City Council (BHCC) Children’s Social Care
* BHCC Community Safety
* BHCC Health, SEN and Disabilities
* BHCC Housing
* BHCC Lead Member for Adult Social Care
* BHCC Public Health
* Brighton and Sussex University Hospital NHS Trust
* Brighton Housing Trust
* Brighton Oasis Project
* Care Quality Commission
* Cranstoun
* East Sussex Fire and Rescue Service
* Healthwatch
* Kent, Surrey, Sussex Community Rehabilitation Company
* Money Advice Plus
* National Probation Service
* NHS England
* South East Coast Ambulance Service NHS Foundation Trust
* Sussex Community NHS Foundation Trust
* Sussex Partnership NHS Foundation Trust

**Partners of the East Sussex SAB**

* East Sussex Adult Social Care and Health
* NHS East Sussex Clinical Commissioning Group
* Sussex Police
* Care for the Carers
* Care Quality Commission
* Change, Grow, Live (CGL)
* District and borough councils
* East Sussex County Council (ESCC) Children’s Social Care
* ESCC Trading Standards
* East Sussex Safeguarding Children Partnership
* East Sussex Fire and Rescue Service
* East Sussex Healthcare NHS Trust
* Healthwatch
* Her Majesty’s Prison Service (HMPS) Lewes
* Kent, Surrey, Sussex Community Rehabilitation Company
* Lay members
* National Probation Service
* NHS England
* Registered Care Association
* South East Coast Ambulance Service NHS Foundation Trust
* Sussex Community NHS Foundation Trust
* Sussex Partnership NHS Foundation Trust
* Voluntary and community sector representation

**Partners of the West Sussex SAB**

* West Sussex County Council
* NHS West Sussex Clinical Commissioning Group
* Sussex Police
* Brighton and Sussex University Hospital NHS Trust
* Care Quality Commission
* District and borough councils
* HMPS Ford
* Local Safeguarding Children’s Board
* National Probation Service
* NHS England
* Queen Victoria Hospital Foundation NHS Trust, East Grinstead
* South East Coast Ambulance Service NHS Foundation Trust
* Surrey and Sussex Healthcare
* Sussex Community NHS Foundation Trust
* Sussex Partnership NHS Foundation Trust
* West Sussex County Council (WSCC) Community Safety and Wellbeing
* WSCC Lifelong Services
* WSCC Public Health
* West Sussex Fire and Rescue Service
* Western Sussex Hospitals NHS Foundation Trust
* West Sussex Partners in Care
* Voluntary and community sector representation

# Appendix 2: IJAM agenda and minutes templates

**Sussex Safeguarding Adults Boards**

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Brighton and Hove Safeguarding Adults Board logo 
East Sussex Safeguarding Adults Board logo 
West Sussex Safeguarding Adults Board logo 

**Adult death protocol**

**Initial joint agency meeting (IJAM) agenda**

|  |  |
| --- | --- |
| **Item** | **Subject** |
| 1. | **Welcome, introductions and apologies:**   * Housekeeping * Confidentiality and equal opportunities statement * Purpose of meeting |
| 2. | **Background information on case:**   * Pen picture of adult * Nature of concern(s) * Relevant historical information, including any known safeguarding concerns or enquiries * Confirm criteria for adult death protocol met |
| 3. | **Initial information sharing and risk assessment, including risk to others** |
| 4. | **Confirm lead agency and other agencies involved** |
| 5. | **Consider other enquiry or investigatory processes, including:**   * [Section 42 safeguarding enquiry](http://sussexsafeguardingadults.procedures.org.uk/pkotq/sussex-safeguarding-adults-procedures/recognising-and-reporting-abuse-and-neglect#s2809) * [Section 47 child protection enquiry](https://sussexchildprotection.procedures.org.uk/zkypht/response-to-child-protection-referrals/section-47-enquiries) * [Serious Incident Process](https://www.england.nhs.uk/patient-safety/serious-incident-framework/) * [LeDeR](https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/) * Consider if [criteria for a SAR](https://www.eastsussexsab.org.uk/documents/sussex-sar-protocol/) are indicated |
| 6. | **Family considerations** |
| 7. | **Agreed action plan with timescales** |
| 8. | **Joint agency media strategy** |
| 9. | **Feedback to other parties** |
| 10. | **AOB, including date of next meeting if required** |

|  |
| --- |
| **Statement of confidentiality and equal opportunities** |
| All information discussed in this meeting is confidential. Organisations and individuals will aim to maintain the balance between the need for confidentiality and the sharing of information on a ‘need to know’ basis in the interests of safeguarding adults. In certain circumstances it may also be necessary to make information from the meeting available to third parties such as other professionals involved in the care and support of adults and this will be recorded.  It is expected that all participants in the meeting will treat each other with respect, and that sensitivity to aspects of difference such as gender, disability, ethnicity, cultural and religious background is observed.  Any comments that contribute to discrimination are not acceptable and will be challenged by the Chair and other members of the meeting. |

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**Adult death protocol**

**Initial joint agency meeting (IJAM) minutes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of the deceased adult** | | | |
| Name: |  | ASC number (if applicable): |  |
| Date of birth: |  | Gender: |  |
| Address: |  | | |

|  |  |
| --- | --- |
| **Meeting or discussion details** | |
| Date of meeting or discussion: |  |
| Venue or location: |  |
| Meeting Chair: |  |
| Lead adult social care rep: |  |
| Lead police rep: |  |
| Lead health rep: |  |
| Attendees: |  |
| Apologies: |  |

|  |
| --- |
| **Minutes** |
| Pen picture of adult and background information, including historical information: |
|  |
| Summary of notification of unexpected death and significant information: |
|  |
| Initial information sharing, intelligence and concerns (to include summary of risk and current measures in place): |
|  |
| Consideration of statutory investigation processes: |
|  |

|  |  |  |
| --- | --- | --- |
| **Agreed actions from the meeting or discussion** | | |
| Action: | By whom: | Timescale: |
|  |  |  |
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|  |  |  |
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|  |  |  |

|  |
| --- |
| **Summary** |
| Feedback to others: |
|  |

|  |  |  |
| --- | --- | --- |
| Is another meeting or discussion required? | | Yes  No |
| Proposed date, time and venue: |  | |

|  |  |
| --- | --- |
| **Minutes completed by** | |
| Name: |  |
| Role: |  |
| Team: |  |
| Contact details: |  |
| Date: |  |

# Appendix 3: Follow-up meeting agenda and minutes templates

**Sussex Safeguarding Adults Boards**

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**Adult death protocol**

**Follow-up meeting agenda**

|  |  |
| --- | --- |
| **Item** | **Subject** |
| 1. | Welcome, introductions and apologies |
| 2. | Purpose of meeting |
| 3. | Review of actions from each agency |
| 4. | Next steps including:   * Case recommendations * Strategic actions * Governance |
| 5. | AOB |
| **Statement of confidentiality and equal opportunities** | |
| All information discussed in this meeting is confidential. Organisations and individuals will aim to maintain the balance between the need for confidentiality and the sharing of information on a ‘need to know’ basis in the interests of safeguarding adults. In certain circumstances it may also be necessary to make information from the meeting available to third parties such as other professionals involved in the care and support of adults and this will be recorded.  It is expected that all participants in the meeting will treat each other with respect, and that sensitivity to aspects of difference such as gender, disability, ethnicity, cultural and religious background is observed.  Any comments that contribute to discrimination are not acceptable and will be challenged by the Chair and other members of the meeting. | |

**Sussex Safeguarding Adults Boards**

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East Sussex Safeguarding Adults Board logo 
West Sussex Safeguarding Adults Board logo

**Adult death protocol**

**Follow-up meeting minutes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of the deceased adult** | | | |
| Name: |  | ASC number (if applicable): |  |
| Date of birth: |  | Gender: |  |
| Address: |  | | |

|  |  |
| --- | --- |
| **Meeting or discussion details** | |
| Date of meeting or discussion: |  |
| Venue or location: |  |
| Lead agency: |  |
| Meeting Chair: |  |
| Attendees: |  |
| Apologies: |  |

|  |
| --- |
| **Minutes** |
| Purpose of meeting: |
|  |
| Review of actions from each agency: |
|  |

|  |  |  |
| --- | --- | --- |
| **Agreed actions from the meeting or discussion** | | |
| Action: | By whom: | Timescale: |
|  |  |  |
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|  |  |  |
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|  |  |  |

|  |  |
| --- | --- |
| **Minutes completed by** | |
| Name: |  |
| Role: |  |
| Team: |  |
| Contact details: |  |
| Date: |  |