



Sussex Adult Death Protocol

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Contents

- Foreword by the Independent Chairs of the East Sussex, Brighton and Hove and West Sussex Safeguarding Adults Boards 1
- Foreword by Chief Superintendent of Public Protection, Sussex Police.....2
- Introduction and purpose of protocol3
- Scope and criteria4
 - Definition of an adult for the purpose of this protocol 4
- Raising a referral for the adult death protocol5
- Flowchart – Overview of Adult Death Protocol (ADP) – if police are in attendance and immediate action needed6
- Flowchart – Overview of Adult Death Protocol (ADP) – to be followed if ADP Referral Form received into MASH by referring agency.7
- Legal considerations9
- Effective multi-agency working9
- Working with families..... 10
- Initial joint agency meeting (IJAM)..... 12
- Follow-up meeting 13
- Complaints or disputes 13
- Review of this protocol 14
- Appendix 1: Parties to this protocol 15
- Appendix 2: IJAM agenda and minutes templates 18
- Appendix 3: Follow-up meeting agenda and minutes templates23

Foreword by the 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, 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.

The Adult Death Protocol is the result of the joint efforts of the 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.

A handwritten signature in black ink, appearing to be 'Annie Callanan', written over a horizontal line.

Independent Chair (Vacant)
East Sussex SAB

Annie Callanan, Independent Chair
Brighton & Hove and West Sussex SABs

Foreword by Chief Superintendent of Public Protection, Sussex Police



In 2020 – 2021 NHS Digital collated data from all 152 local authorities in England. Over 500,000 safeguarding concerns were raised nationally in relation to vulnerable adults and this figure is growing exponentially year on year.

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.

A handwritten signature in black ink that reads "James Collis". The signature is written in a cursive style with a horizontal line underneath the name.

James Collis
Chief Superintendent Public Protection

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.

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 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](#) and the [Sussex Information Sharing Guide and Protocol](#).

Scope and criteria

The purpose of the ADP is to identify deaths of adults within the community or care settings where there is an indication of abuse and neglect. The abuse or neglect is not only when it relates to the circumstances of their death but can also be recent abuse or neglect in their lives.

Definition of an adult for the purpose of this protocol

This is set out in [Sections 42 to 47 of the Care Act](#) in relation to adult safeguarding and applies to any person aged 18 years or older 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.

The adult death protocol applies to the following criteria:

- **an adult dies in unexpected or unnatural circumstances, and**
- **there is suspicion, or it is known, that they suffered from recent abuse or neglect or that it was a contributory factor in their death, and**
- **the abuse or neglect is believed to have been caused by a third party.**

This protocol has been created to compliment these statutory responsibilities by encouraging early information sharing and collaboration between the three statutory agencies.

Any situation involving a suspected homicide will not be covered by this protocol, and the homicide investigation and [Domestic Homicide Review process](#) takes precedence.

Where the case is initially treated as a suspected homicide by police but subsequent enquires reveal that the death is non-suspicious and no longer being treated as a suspected homicide, if the ADP criteria is met, the protocol should be followed.

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 suspicion, or it is known, that they suffered from recent abuse or neglect or that it was a contributory factor in their death 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 completing and emailing the [ADP Referral Form](#) to the relevant Police Multi-Agency Safeguarding Hub (email below) with a summary of the case including details of abuse and/or neglect, the key information of the adult and contact details of the known agencies involved.

West Sussex
WS_PSH@sussex.police.uk

Wealden Lewes Eastbourne
MASH.Eastbourne@sussex.police.uk

Hastings and Rother
MASH.Hastings@sussex.police.uk

Brighton and Hove
Brighton.Mash@sussex.police.uk

or by contacting the Sussex Police contact centre on 101 or [online](#) for referrals over weekends/evenings and 999 in an emergency. 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 deceased 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 contact the relevant statutory partners to assess whether the ADP criteria applies and if an Initial Joint Agency Meeting (IJAM) will be arranged. Further details of this process are set out within the flowchart on the next page.

Flowchart – Overview of Adult Death Protocol (ADP) – if police are in attendance and immediate action needed

Immediately
<p>Police or professionals are in attendance of a death which they believe fits the ADP</p> <ul style="list-style-type: none"> • 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 deceased
Next
<p>Ambulance and Police attend location of the deceased</p> <ul style="list-style-type: none"> • 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 deceased with the attending medical practitioner • Consider safeguarding risk to other adults and / or children and raise a safeguarding concern is required • Engage staff / family and explain ADP process • If a homicide is suspected, then the homicide process takes primacy
Next
<p>Attending DI notifies MASH DI to arrange Initial Joint Agency Meeting (IJAM) IJAM to have representation from statutory partners i.e.</p> <ul style="list-style-type: none"> • Police • NHS Sussex Integrated Care Board • Adult Social Care and Health • AND any other agency by invitation as required
Next – Within 24 hours
<p>IJAM chaired by MASH DI</p> <ul style="list-style-type: none"> • Initial information sharing, risk assessments, action plan (including consideration of risk to other adults / children) • Confirm lead agency • Referring agency completes the ADP Referral Form • Consider involvement from any other relevant agency and plan to request additional information • Confirm other enquiry / investigation processes • Consider if the criteria for a SAR / DHR referral may be indicated

Flowchart – Overview of Adult Death Protocol (ADP) – to be followed if ADP Referral Form received into MASH by referring agency.

Immediately
<p>Unexpected adult death in which ADP criteria are indicated identified by agency</p> <ul style="list-style-type: none"> • The identifying agency contacts Sussex Police MASH by completing the ADP Referral Form with the nature of referral and concerns • MASH DI is notified and makes contact with both the Adult Social Care and Health Safeguarding leads and the NHS Sussex Integrated Care Board (ICB) safeguarding team should be involved in these initial discussions to discuss if ADP criteria is met. • Consider safeguarding risk to other adults and / or children and initial immediate action to safeguard if necessary (Lead to be identified) • Discussion to be held on most appropriate agency to lead the ADP – This should either be agency who has identified concerns or has most information about the adult
Next
<p>Police to ascertain location of deceased and consider Fast Track Actions:</p> <ul style="list-style-type: none"> • Police make contact with HM Coroner and inform them of concern • Location of deceased is identified, and any FTA (such as blood samples or photography) is considered and discussed with HM Coroner's officer • Police secure copy of cause of death including details of PM if one took place • If a homicide is suspected, then the homicide process takes primacy
Next – Within 72 hours (working)
<p>IJAM chaired by Police</p> <ul style="list-style-type: none"> • Initial information sharing, risk assessments, action plan (including consideration of risk to other adults / children) • Agencies to supply chronologies, if practicable, or similar information to avoid changes later • Consider involvement from any other relevant agency and plan to request additional information • Confirm other enquiry / investigation processes • Discuss risk to other adults and safeguarding plans/reassurance • Consider if the criteria for a SAR / DHR referral may be indicated • ADP Referral Form outcome section to be completed during the IJAM to include if criteria has been met/not met with reasoning and agreed outcome/actions and which agencies will take these forward. • If a second meeting is required confirm chairing arrangements with lead agency

Within 6 weeks

Police

- Investigation into potential criminal offences

Coroner

- Preliminary and final post-mortem examination report provided to the coroner and with coroner's agreement to the police

Any other enquiry or investigatory process

- Review of health and social care information

Next

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 including the referring agency
- Further consideration if the criteria for a [SAR](#) / [DHR](#) referral may be indicated

Next

Follow up meeting to be arranged by lead agency if appropriate

- 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](#) set out a clear legal framework for adult safeguarding and are supported by the [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](#) 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](#), 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](#).

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](#).

Working with families

When an adult dies unexpectedly and in suspicious circumstances, effective and appropriate communication with families is of the utmost 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. Taking a trauma-informed approach to supporting family members, is key to managing wellbeing and preventing re-traumatisation
- 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](#).

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](#), 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 and Health (ASCH) and the NHS Sussex Integrated Care Board (ICB) in the relevant area to agree attendees. As a minimum there should always be representation from the three statutory partners. The ICB will attend the initial IJAM and identify and delegate actions thereafter to the appropriate health provider organisations. Similarly, the senior manager representative from ASCH 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 Sussex ICB but the appropriate health provider organisation identified at the IJAM.

[Sussex Safeguarding Adults Escalation and Resolution Protocol](#). The process outlined in this protocol provides for the escalation and resolution of such disagreements where an agency or professional has a concern with regard to a decision made by other professionals or another agency in relation to adult safeguarding and mental capacity within adult safeguarding.

Review of this protocol

The protocol will be reviewed by representative(s) nominated by the Brighton & Hove, East Sussex and West Sussex SABs on agreement as to the regularity 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.

Reviews will take place every three years unless significant changes are required. Evaluations will take place periodically to ensure effective use of the ADP by Partners. Recording of ADP cases will be maintained and monitored by Sussex Police.

Appendix 1: Parties to this protocol

Partners of the Brighton & Hove SAB

- Brighton & Hove Health and Adult Social Care
- 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
- NHS Sussex Integrated Care Board
- 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 Sussex Integrated Care Board
- 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
- Lay members
- 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 Sussex Integrated Care Board
- Sussex Police
- Brighton and Sussex University Hospital NHS Trust
- Care Quality Commission
- District and borough councils
- HMPS Ford
- Local Safeguarding Children's Board
- 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



Adult death protocol Initial joint agency meeting (IJAM) agenda

Item	Subject
1.	Welcome, introductions and apologies: <ul style="list-style-type: none"> • Housekeeping • Confidentiality and equal opportunities statement • Recording of meeting if administration support is not available • Statement of Professional Differences • Purpose of meeting
2.	Background information on case: <ul style="list-style-type: none"> • ADP Referral Form • Pen picture of adult • Chronology if available • 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: <ul style="list-style-type: none"> • Section 42 safeguarding enquiry • Section 47 child protection enquiry • Serious Incident Process • LeDeR • Consider if criteria for a SAR are indicated
6.	Family considerations
7.	Agreed action plan with timescales
8.	Joint agency media strategy

9.	<p>ADP Referral Form outcome section to be completed during the IJAM to include:</p> <ul style="list-style-type: none"> • If the criteria have been met/not met with reasoning • Agreed outcome/actions • Which agencies will take these forward • Feedback to agencies/other parties
10.	<p>AOB</p> <ul style="list-style-type: none"> • Including date of next meeting (if required) and chairing arrangements with lead agency

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.

Statement of professional differences

'It is acknowledged that when working in the arena of safeguarding, it is inevitable that from time to time there will be professional differences. This is a positive activity and a sign of good professional practice and effective multi-agency working. During this meeting practitioners, irrespective of their seniority are encouraged to say if they feel that decisions, practice, or actions do not effectively promote safeguarding or address objectives of this Adult Death Protocol.

Sussex Safeguarding Adults Boards



Adult death protocol

Initial joint agency meeting (IJAM) minutes

Details of the deceased adult			
Name:		ASCH 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 and chronology if available:

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:
Outcome section of the ADP Referral Form completed		

Summary

Feedback to others:

--

Is another meeting or discussion required?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
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



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: <ul style="list-style-type: none"> • Case recommendations • Strategic actions • Governance
5.	AOB
<p>Statement of confidentiality/equal opportunities and professional differences</p> <p>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.</p> <p>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.</p> <p>Any comments that contribute to discrimination are not acceptable and will be challenged by the Chair and other members of the meeting.</p> <p>'It is acknowledged that when working in the arena of safeguarding, it is inevitable that from time to time there will be professional differences. This is a positive activity and a sign of good professional practice and effective multi-agency working. During this meeting practitioners, irrespective of their seniority are encouraged to say if they feel that decisions, practice or actions do not effectively promote safeguarding or address objectives of this Adult Death Protocol.</p>	

Sussex Safeguarding Adults Boards



Adult death protocol Follow-up meeting minutes

Details of the deceased adult			
Name:		ASCH 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:

Minutes completed by

Name:

Role:

Team:

Contact details:

Date: