Safeguarding Adults Review (SAR) Protocol and Guidance

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Contents

Safeguarding Adults Executive Board (SAEB) Vision Statement

The Safeguarding Adults Executive Board (SAEB) is a statutory partnership that sets the strategic direction for safeguarding and has responsibility for overseeing and leading on the protection of adults who are experiencing, or who are at risk of abuse or neglect living across the Royal Borough of Kensington and Chelsea and Westminster City Council (referred to as the Bi-Borough).

Our vision

Our vision is that people living in the Bi-Borough have the right to live a life free from harm, where communities:

- Have a culture that does not tolerate abuse
- Work together to prevent abuse
- Know what to do when abuse happens.

Our values and behaviours

The board believes that adult safeguarding takes **courage** to acknowledge that abuse or neglect is occurring and to overcome our natural reluctance to face the consequences for all concerned by shining a light on it.

The board promotes **compassion** in our dealings with people who have experienced abuse and neglect, and in our dealings with one another, especially when we make mistakes. The board promotes a culture of learning rather than blame.

At the same time, as members of the board, we are clear that we are **accountable** to each other, and to the people we serve in the two boroughs.

The vision and values outlined above are central to the ethos of the Safeguarding Adults Review (SAR) Protocol and Guidance. The protocol is also underpinned by a Making Safeguarding Personal approach, which ensures that the human stories from SARs are central and that learning from reviews reflects the six safeguarding principles set out in the Care Act 2014:

- **Empowerment** – presumption of person led decisions and informed consent.
- **Prevention** – it is better to take action before harm occurs.
- **Proportionality** – the least intrusive response appropriate to the risk presented.
- **Protection** – support and representation for those in greatest need.
- **Partnership** – services offer local solutions through working closely with their communities. Communities have a part to play in preventing, detecting and reporting abuse and neglect.
- **Accountability** – accountability and transparency in delivering safeguarding.

1. Introduction

1.1 The Care Act 2014 places a statutory duty on Safeguarding Adults Boards (SABs) to undertake Safeguarding Adults Reviews (SARs).

1.2 This protocol applies to all partners of the Bi-Borough Safeguarding Adults Executive Board (SAEB) who have collective responsibility to support the Board to meet its statutory duties. It will support professionals to decide when to refer a case for consideration of a SAR as well as providing guidance on the SAR process itself.

1.3 The protocol aims to ensure a consistent and robust approach to the process and practice in undertaking SARs that follows both statutory guidance and local policy and provides a framework which enables SARs to be undertaken in an effective, timely and proportionate way with the primary aim of multi-agency learning.

1.4 The protocol has been informed by key messages from the National Analysis of SARs April 2017 – March 2019, the Second National Analysis of SARs April 2019 – March 2023 and the SAR Quality Markers, produced by the Social Care Institute of Excellence (SCIE). The SAR Quality Markers Checklist should be used alongside this protocol at all stages of the SAR process to support good practice.

1.5 The protocol should also be read in conjunction with the Care and Support Statutory Guidance and the London Multi-Agency Adult Safeguarding Policy and Procedures. Section 2.9 of the Safeguarding Policy and Procedures specifically covers SARs.

2. Purpose of a SAR

2.1 The purpose of undertaking a SAR is to:

- Determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death.
- Establish what lessons can be learned from the case and be applied to future cases to prevent similar harm occurring again.

2.2 SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

2.3 The SAR process is not to hold any individual or organisation to account, as other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of regulation, such as the Care Quality Commission (CQC), Social Work England (SWE), the Nursing and Midwifery Council (NMC), and the General Medical Council (GMC).

2.4 The SAR process is not intended to duplicate or replace other agencies own internal or statutory review procedures to investigate serious incidents, or their own mechanisms for reflective practice.

2.5 As set out within chapter 14.167 of the Care and Support Statutory Guidance, SARs should be based on the following principles:

- A culture of continuous learning and improvement across the organisations that work together to safeguard and promote wellbeing and empowerment of adults, identifying opportunities to draw on what works well and promote good practice.
- The approach to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families should be invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.

3. SAR criteria

3.1 Section 44 of the Care Act 2014 outlines the circumstances in which Safeguarding Adults Boards (SABs) **must undertake a SAR (mandatory SAR)** when:

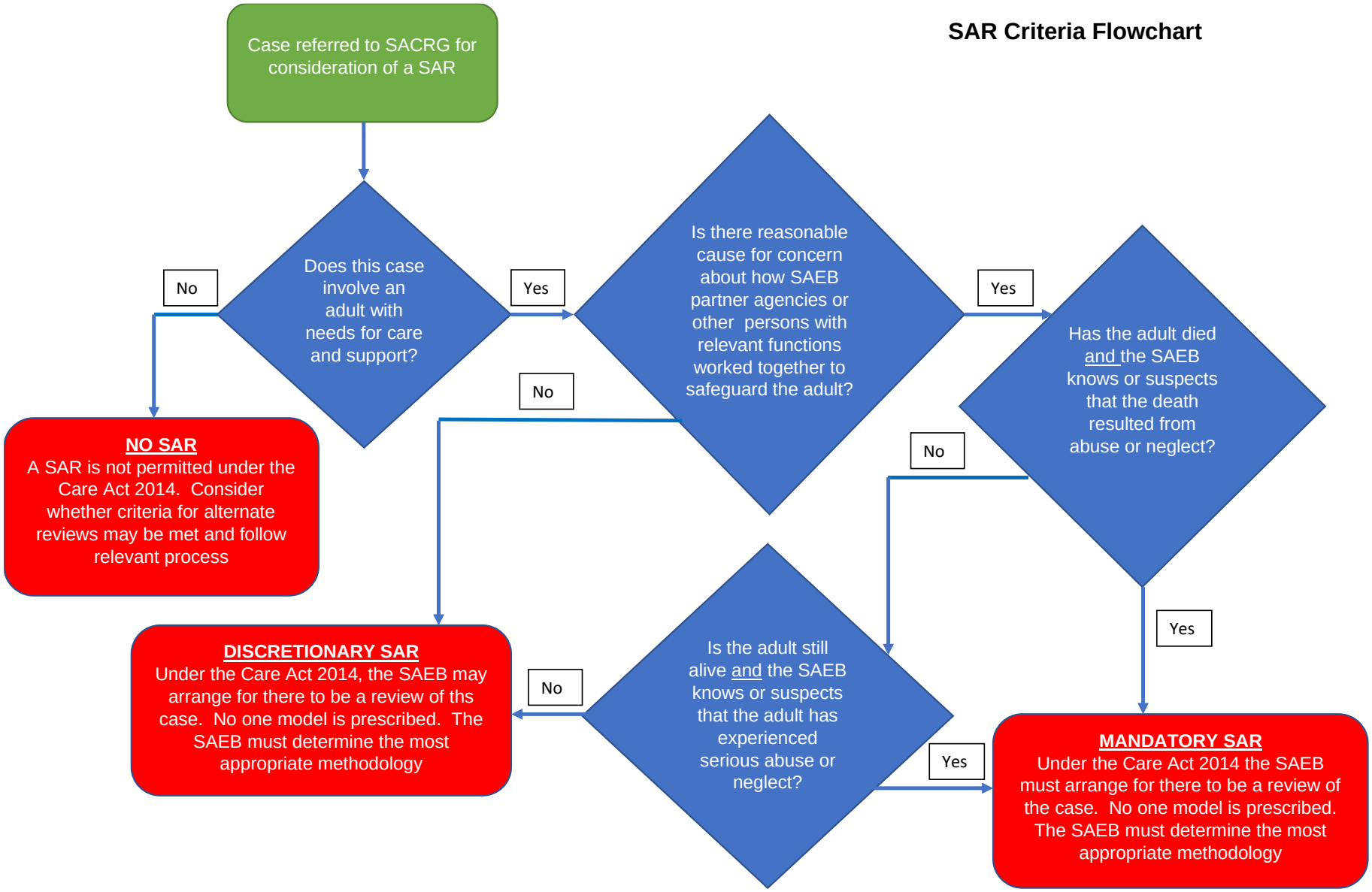
- An adult in its area dies as a result of abuse or neglect, whether known or suspected; **or**
- Where the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect; **and**
- There is concern that partner agencies could have worked together more effectively to protect the adult.

3.2 The Care Act also states that SABs **can arrange for a SAR to be commissioned in any other situation** where the criteria are not met, but it is clear that there are valuable lessons to be learnt with the aim of improving how agencies work together, to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future **(discretionary SAR).**

3.3 The person referred for a SAR must have care and support needs; however, these do not need to be met by any statutory or other agency.

3.4 A flowchart outlining the decision-making framework for the SAR criteria is set out on page five.

SAR Criteria Flowchart



4. SAR operating framework and governance

4.1 The SAEB has the statutory responsibility for determining whether a SAR is required, making arrangements for it to be undertaken, overseeing actions to respond to findings and ensuring that learning is shared and supports improvements in systems and practice. A flowchart providing an overview of the SAR process can be found at Appendix 1.

4.2 An overview of the key roles and responsibilities within the SAR operating framework can be found at Appendix 2.

4.3 Responsibility for the management of SARs is delegated to the Safeguarding Adults Case Review Group (SACRG). The terms of reference for the SACRG are reviewed annually.

4.4 The SAB of the host authority (i.e. the local authority area where the abuse or neglect has taken place) will be responsible for liaising with all relevant agencies, including the SAB in any placing authorities to agree on how the SAR will be undertaken. SABs should cooperate across borders and requests for information should be responded to as a priority, as detailed within the ADASS Safeguarding Adults Policy Network Guidance.

4.5 The Care Act places a duty of cooperation on all Board members to contribute to such reviews. Section 45 of the Act outlines a specific provision regarding the supply of information to SABs, that if information this is requested is for the purpose of enabling or assisting the SAB to perform its functions, including that of undertaking a SAR, then agencies have to share any relevant information they hold.

4.6 Complaints about a SAR and/or any of its functions should be raised in the first instance with the SAR Panel Chair and / or SACRG Chairs for resolution. If in the unlikely event that this cannot be resolved through this process, then matters should be escalated to the SAEB Independent Chair. Complaints can be referred to the Local Government Ombudsman (LGO) if resolution cannot be achieved through the earlier stages outlined. Further information is available in the LGO report 'Casework Guidance Statement: Complaints about Safeguarding Adults Boards'.

5. Referral process

5.1 Any professional or agency representative can make a referral for a SAR for any case in which they believe the Section 44 criteria are met, by completing the SAR referral form (Appendix 3). Referrals should be sent to the SAEB via secure email at makingsafeguardingpersonal@rbkc.gov.uk Referrers will receive an email from the SAEB Support Team to confirm receipt of the SAR referral.

5.2 Practitioners are encouraged to discuss their concerns with their organisation's safeguarding lead or the SAEB Business Manager prior to making a referral. It is important that referrers complete all sections of the referral form in full, include all relevant and factual information and provide details on how the SAR criteria are met. Referrers should refer to the guidance note at Appendix 4.

5.3 Upon receipt of the SAR referral, the SAEB Business Manager will discuss with the HOS and Strategic Safeguarding Manager and if reasonable will then notify the SACRG Chairs and SAEB Independent Chair of the referral. If they are satisfied it is reasonable (given the

mandatory criteria and discretionary powers) to give full consideration of the referral then the process for presentation to the SACRG will commence. If the referral does not meet the SAR criteria, then this will not be taken forward to the SACRG for their consideration. When SAR referrals are submitted inappropriately in place of a safeguarding concern, the referrer will be signposted to the safeguarding referral pathway.

5.4 The SAEB Support Team will triage the referral to ensure that all of the necessary information has been provided and may contact the referrer for further discussion of the referral.

5.4 The SAEB Business Manager will write to all relevant agencies to request that they complete an initial summary of their involvement (Appendix 5). These should be completed within 10 working days.

5.5 If a family member or representative of an adult approaches the SAEB or SAEB partner agency to raise a SAR referral, it will be the responsibility of that body to identify the most appropriate route to take this request forward. This may result in a SAEB partner agency completing a SAR referral form on their behalf or may also involve advising the family member why the request does not meet the criteria for a SAR and that it would not be appropriate to raise this. Family members or representatives will be given clear information about the distinction between SARs and the complaints process.

6. Decision making process

6.1 The SACRG meets on a six-weekly basis to consider and make decisions in respect of SAR referrals, co-ordinate SARs in progress and monitor progress of SAR action plans. A log of SARs referrals under consideration will be maintained and presented at each SACRG meeting. Members of the SACRG will be sent the relevant paperwork in advance of meetings for their consideration.

6.2 The referring agency will be asked to attend the SACRG to present the referral, and other relevant agencies will be invited to the meeting to contribute to the discussion and decision making. The referring agency will be supported to make the presentation.

6.3 The decision about whether to undertake a SAR, and the nature of the SAR that is required, will need to take into account factors related to the case and the local context. The primary consideration is whether there is a statutory obligation to undertake a SAR using the criteria in Section 44 of the Care Act. The rationale for any recommendations should be clear, defensible and reached in a timely fashion. Any delays in decision making should be referenced and explained.

6.4 The SACRG will also take into account whether any other statutory reviews or any other significant proceedings (such as a police investigation or Coroner's Inquest) are taking place. Refer to section 7 – Interface with Section 42 enquiries, other reviews and parallel proceedings.

6.5 Some cases referred to the SACRG may involve one or more local authorities or other statutory organisations. In such cases, the SAEB Business Team will notify the SAEB Independent Chair and then contact the relevant local SAB to discuss next steps.

6.6 The SACRG will submit their recommendation to the SAEB Independent Chair as to whether the SAR criteria has been met, whether a SAR or other review is suggested and if so, what

methodology should be used. In making a decision to recommend a SAR, the SACRG should reach a consensus. If the group cannot come to a consensus, the final decision will rest with the Independent Chair.

6.7 The Independent Chair is responsible for reviewing the recommendations and endorsing the decision to undertake a review or not.

6.8 The SAEB Business Manager will inform the referrer in writing of the decision, and for cases which progress to a SAR, discussions will take place regarding how to inform the adult and / or their family / representative. The adult and / or their family / representative will not be informed if there is not going to be a SAR unless there are exceptional circumstances.

6.9 If the outcome of the referral is not to progress with a SAR, and the referrer is dissatisfied, they should notify the SACRG Chairs in writing who will discuss this with the referrer and if appropriate request that the SACRG reviews the decision. If a decision not to undertake a SAR is upheld, further discussions will take place with the SAEB Independent Chair.

7. Interface with Section 42 enquiries, other reviews and parallel proceedings

7.1 In the majority of cases a safeguarding process via a Section 42 enquiry will have been completed in relation to the circumstances of the case before a SAR referral is raised. It is important to note that a SAR is not an alternative to a safeguarding enquiry or other investigatory process, and as such will ordinarily only be considered following the conclusion of a statutory investigation (whether that be a police investigation, Section 42 safeguarding enquiry, or Patient Safety Incident (PSIT) report or equivalent undertaken by the NHS). However, there may be situations in which enquiries or investigations have not been completed, but the circumstances of the case necessitate that a SAR might be more effective than a Section 42 enquiry or other investigatory process. Decisions regarding this will be made on a case-by-case basis.

7.2 The SACRG will seek to identify from the outset whether there are any other investigatory proceedings or reviews taking place in relation to the same concerns. These may include:

- Criminal proceedings
- Coroner's inquests
- NHS Patient Safety Incident Response Framework (PSIRF)
- Learning Disability Mortality Reviews (LeDeR)
- Child Safeguarding Practice Reviews
- Domestic Homicide Reviews
- MAPPA Serious Case Reviews
- Mental Health Homicide Reviews or NHS Independent Investigation Reports
- Fatal Fire Reports

7.3 Where there are parallel processes, the SAR Terms of Reference (TOR) should outline how the process will dovetail with other relevant investigations to avoid, as much as possible, duplication of work, unnecessary delay and confusion to all parties, including the adult's family.

7.4 When a SAR referral overlaps with another review process there will be early liaison with the decision makers of those related review processes to determine how the reviews can be

effectively managed and to avoid duplication, or decide which process should take precedence, or whether there are any opportunities for a joint review.

7.5 Where there are ongoing criminal investigations, court hearings or coroner's inquests the SACRG and Independent Chair will need to consider the potential impact a SAR may have upon such proceedings and whether the start of the review should be delayed until the completion of the proceedings. In such circumstances, advice should be sought from the police, Coroner's Office, Crown Prosecution Service and/or legal services, on if, and how the SAR should take account of these proceedings.

7.6 The Interface between SARs and Coronial Processes Best Practice Guidance has been developed to support an effective interface between Safeguarding Adults Reviews (SARs) and Coronial Processes. The SACRG will refer to this guidance in their communications with the Coroner's Office and use templates as appropriate.

7.7 In relation to coroner's proceedings, in situations in which the coroner's investigation identifies a concern that there is a risk of other deaths occurring in the future, the coroner will consider issuing a 'Prevention of Future Death' or 'Regulation 28' report, setting out the concerns and what action a person, body or organisation needs to take. All national Regulation 28 notices issued in which there is a safeguarding aspect to the case should be shared the SACRG subgroup so that any relevant single or multi-agency learning can be disseminated across partner agencies as appropriate.

7.8 Effective communication and joint working between the SACRG and the operational teams across the safeguarding partnership is critical in any cases involving parallel proceedings that have also been referred consideration of a SAR.

7.9 Organisations should use their own Serious Incident Reporting (SIR) to notify Chief Executives and the Directorate of any cases in which an adult known to their service has died or experienced serious harm as a result of abuse of neglect. It is important that the internal SIR process ensures any statutory considerations, such as making a SAR referral, are considered from the outset.

7.10 If there is a delay in the start or overall duration of the SAR as a consequence of a concurrent parallel process, a clear rationale will be recorded and the SACRG will ensure that any identified learning at the earlier stages of the process is shared and taken forward with relevant parties.

8. Methodology and terms of reference

8.1 Once a decision is made to commission a SAR, key members of the SACRG will hold a scoping meeting to identify the methodology best suited to the circumstances of the case and will draft the terms of reference (TOR). The TOR is key in setting out the scope and timescales for the review along with the most important issues to address the learning from the case. A TOR template can be found at Appendix 6.

8.2 SARs can be conducted in a variety of ways using different methodologies. "The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective

learning and improvement action to prevent future deaths or serious harm" (Care and Support Statutory Guidance 14.135).

8.3 A SAR Panel will be convened, which is set up to oversee the delivery of the review and made up of representation from senior managers of all organisations involved in the case. Guidance for SAR Panel members is provided in Appendix 7. In many cases this may constitute the core membership of the SACRG, although other agencies and professionals may be approached if required. The SACRG is responsible for ensuring the effectiveness of the Panel to ensure timely completion of reviews and producing of reports which meet the terms of reference for the review and produce SMART recommendations.

9. Commissioning a SAR

9.1 In parallel to selecting the methodology and drafting the TOR, the SAEB Business Manager will support the commissioning process and will act on behalf of the Board to provide support and oversight to the contractual arrangements with the Independent Reviewer.

9.2 A lead reviewer, who has had no previous involvement in the management of the case and no conflicts of interest will be appointed for each SAR. Consideration should be given to the reviewer's experience and expertise in this area, to ensure that they have the appropriate skills and be able to lead a SAR process.

9.3 The reviewer will need to provide assurance that they understand requirements of the General Data Protection Regulations and how to impacts on the retention of any information they will store in relation to the review.

9.4 The reviewer should be able to produce a SAR report which fulfils the terms of reference for the review and is compliant with the SAR Quality Markers.

10. Timescales

10.1 SARs must be completed in a timely manner, and once a decision is made to undertake a SAR, it is good practice for it to be completed within six months.

10.2 It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues which emerge from the review and need to be considered without delay should be brought to the attention of the SAEB.

10.3 The reasons for any delays should be clearly recorded within minutes of SACRG and / or SAR Panel meetings.

11. The involvement of the adult, family members and representatives

11.1 Adults affected by significant abuse and neglect, or those bereaved by losing a family member to abuse or neglect will have a wide range of support needs. The lead reviewer, SAEB Business Manager and SAR Panel Chair have an important role to play in ensuring that adults and their families are given the opportunity to be integral to SARs that their wishes, feelings and needs are placed at the heart of the review.

11.2 It is important that consideration is given from the outset as to the best means of notifying the adult(s) (where possible) and their family/representatives that a review is taking place and to invite and support them to contribute to the review, if they wish to do so.

11.3 The SAEB Business Manager and Independent Reviewer will make contact with the adult and/or their family/representatives early on in the process to establish:

- Why and how a SAR will be undertaken.
- If they would like to be involved and how – for example views contributed via telephone / virtual or face to face meeting, or attendance at SAR meetings.
- Any support or adjustments needed to facilitate their involvement.
- Their initial views, wishes, concerns and any answers/outcomes they would like to achieve from the SAR.

11.4 All adult(s) and family members/representatives involved in a SAR should be given clear information about the SAR process so that understand the distinction, for example between a SAR and a complaints process. Adults and/or their family/representatives should be provided with a copy of the SAEB SAR leaflet for family and friends.

11.5 Consent from the adult(s) and/or their family is not required for the review to go ahead.

11.6 Where the adult can be involved and has mental capacity to engage within the SAR, the involvement of any family/carers should be agreed with the individual. In any case where the adult lacks the necessary mental capacity to be involved in the review, family/carers should be consulted in accordance with the Mental Capacity Act 2005.

11.7 Consideration should be given as to whether the adult and/or their family may benefit from the support of an advocate. In situations in which the adult(s) would have "substantial difficulty in participating themselves" and there is no other appropriate person to assist them, the local authority has a duty under the Care Act 2014 to involve an independent advocate.

11.8 Reasonable support and adjustments should also be made as required to support the adult and/or their family/carers to participate in the SAR. This may include easy read/ large print / translated documents, access to an interpreter, support from a chosen representative, longer meeting times, pre and post meeting briefings.

11.9 Where possible and practicable, the adult and / or family will be consulted with to agree on how the person subject to the SAR will be referred to in the report.

11.10 The adult(s) and their family will be kept updated at key stages of the review and will be notified of the publication of the report. Where appropriate, arrangements will be made to share the report with the adult(s) and their family, prior to publication.

12. Responsibilities to staff

12.1 It is important to acknowledge that the death or serious injury of the individual(s) will have an impact on staff and indeed may be felt at a wider level within the organisation. As soon as a SAR has been agreed, any practitioners directly involved in the care and support of the individual(s) subject to a SAR should be notified of the decision to undertake the review by their agency. The process and circumstances of the review should be fully explained, and practitioners made clear about their involvement. Agencies are responsible for ensuring that staff are offered support in relation to their health and wellbeing where the impact of the case causes distress.

12.2 All relevant practitioners should be given an opportunity to share their experiences and opinions on the case as appropriate to the methodology used. This should include their views about what they felt could have made a difference to the individual(s) and/or family. All agencies must encourage, and support practitioners involved in a SAR to be open and transparent in sharing their views, without fear of blame or reprisal, so that real learning can take place.

13. Report and recommendations

13.1 The final SAR report should outline:

- A sound analysis of what happened.
- Any errors or problematic practice and/or what could have been done differently.
- Why those errors or problematic practice occurred and/or why things were not done differently.
- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become findings (system findings).

13.2 As set out in the Care and Support Statutory Guidance, all SAR reports "should be written in plain and easy to understand language…. and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence".

13.3 Any recommendations within the report must be SMART:

- **S** – Specific; immediately understandable
- **M** – Measurable; will make a difference
- **A** – Accessible; considering resources and capacity
- **R** – Relevant and realistic; drawn from evidence
- **T** – Timely

13.3 The SAR Panel will initially agree the draft report, before this is presented to the SACRG to ensure a sufficient level of analysis, scrutiny and evaluation of evidence.

13.4 The final report will then be presented to the SAEB, usually by the Independent Reviewer for final agreement.

14. Publication

14.1 Upon the SAEB formally agreeing the SAR, the Board will consider the publication and media strategy for the report. The SAEB retains discretion over all aspects of publication, including timing of the publication and to take into account any mitigating factors, such as ongoing parallel proceedings, confidentiality or other legal reasons.

14.2 It may be necessary to delay the publication of reports in some circumstances, for example, pending the conclusion of a criminal investigation or coronial inquest. However, the SAEB will ensure that in the interim agencies progress with implementing the recommendations from the action plan produced from the SAR report.

14.3 Any reports to be published must be fully anonymised unless the adult(s) and/or family members or their representatives agree that the adult(s) first, last or both names can be used. In any event the decision to anonymise the report if this is deemed to be necessary rests with the Independent Chair.

14.4 In the spirit of sharing learning, the SAEB will always aim to publish reports in full but has a power not to publish should the circumstances of the case identify specific risk for which it would not be appropriate for the report to be in the public domain. In such situations, consideration will be given to publishing an executive summary rather than the full report.

14.5 Reports are published on the SAEB website with action plans and learning briefings. Every SAR undertaken within the past year will be summarised in the SAEB Annual Report, along with details of any actions taken or planned in relation to implementing the identified learning.

14.6 All SARs are also submitted to the National SAR Library, which has been developed by the National Network for Chairs of SABs for reviews published from April 2019 onwards. This resource contains SAR reports and associated resources to support those involved in commissioning, conducting and quality assuring SARs.

14.7 Any media and communication issues will usually be coordinated by the Council's Communications Team. This will be done in collaboration with Communications Teams of other relevant agencies involved, alongside agreed representatives of the Board. The SAEB Independent Chair will release a press statement where appropriate.

15. Implementation and evaluation

15.1 The real value of completion of a SAR is to ensure that the relevant learning has led to changes within organisational systems and in practice, so as to ensure safeguarding is improved and to prevent the issues in question happening again.

15.2 The SACRG will consider the recommendations from the report and agree an action plan. The development of an action plan may be delegated to a task and finish group with representation from relevant agencies involved who will report progress back to the SACRG.

15.3 The multi-agency action plan will include:

- The actions that are needed.
- Which agency and/or lead professional is responsible for specific actions.

- Timescales for completion of actions.
- The intended outcomes – what will change as a result?
- Mechanisms for monitoring and reviewing intended improvements.
- The processes for dissemination of the SAR report and/or its key findings.

15.4 Individual agencies may be asked by the SAEB to produce their own internal actions plans if required. This may include recommendations to national bodies.

15.5 The SACRG will monitor progress on all recommendations and may request periodic progress update reports, until the time all actions completed. Reports on the implementation of action plans across the partnership will also be presented to Board meetings by the SACRG Chairs.

15.6 Individual Board members are responsible for ensuring that all actions for which their organisation is responsible for are completed, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. Wherever possible agencies should make every effort to capture learning points and take internal improvement action while the SAR is in process, rather than waiting for the SAR report and action plan.

16. Sharing and embedding learning

16.1 Sharing and embedding learning from SARs is a priority of the SAEB. It is also reflected in the National Quality Board's position statement for Integrated Care Systems (ICSs)[1]. SARs provide a rich source of learning to support continuous professional development as well as a significant evidence base which can help to develop a shared understanding of complex and often challenging areas of adult safeguarding practice.

16.2 The SAEB will produce learning briefings for all SARs to raise awareness of the key learning and to promote reflective discussions amongst front-line practitioners and managers within partner agencies.

16.3 It is the responsibility of SAEB members to ensure that they have mechanisms in place to ensure learning is disseminated effectively throughout their organisations reaching managers and front-line staff. SAEB members who are nominated SAR Champions will be responsible for collating feedback on how the learning outcomes have been communicated to staff working in the Bi-Borough and describe any changes to practice that will be implemented as a result of the SAR. The learning briefing feedback form can be found at Appendix 11.

16.4 The SAEB will also cascade learning through a variety of other mechanisms including multi-agency learning events of workshops and bitesize learning materials, such as podcasts and webinars.

16.5 SAEB members who are responsible for training commissioning and delivery within their organisations will lead on ensuring that learning from SARs is directly reflected within the content of their safeguarding training programmes.

[1] The National Guidance on System Quality Groups sets out the importance of ensuring quality is the organising principle of ICSs and that this involves sharing learning and celebrating best practice.

16.6 The SAEB will ensure that there is a shared approach across the safeguarding partnerships, including the Local Safeguarding Children Partnership and the Safer Communities Partnership to sharing learning emerging from reviews.

16.7 SARs may also identify issues of national significance. Whenever there is an issue of national importance or commonality issues across SARs of importance to central government departments and regulatory bodies, the SAEB will initiate discussions in line with the National Escalation Protocol.

17. Useful resources

17.1 The following resources provide additional information in relation to SARs and adult safeguarding:

National Analysis of Safeguarding Adults Reviews
Second Analysis of Safeguarding Adults Reviews
SCIE Guidance on SARs
Sharing Information
User involvement in Safeguarding

Glossary and acronyms

In using this document, a number of acronyms have been used. The following sets out the acronyms used and provides a definition.

CQC	**Care Quality Commission**	The national body responsible for regulating and inspecting registered care providers.
CSPR	**Child Safeguarding Practice Review**	A CSPR (previously known as a Serious Case Review) is undertaken when a child dies, or the child has been seriously harmed and there is cause for concerns as to the way organisations worked together.
DHR	**Domestic Homicide Review**	A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related to or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.
GMC	**General Medical Council**	A public body that maintains the official register of medical practitioners within the United Kingdom.
ICS	**Integrated Care Systems**	Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. ICSs will be established across England on a statutory basis from 1 July 2022. Each ICS will include: • An **Integrated Care Partnership (ICP)** - a statutory committee formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. • An **Integrated Care Board (ICB)** – a statutory NHS organisations responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established, CCGs will be abolished.
LeDeR	**Learning Disabilities Mortality Review Programme**	The LeDeR Programme has been set up by NHS England to improve the health and social care of people with learning disabilities. Under LeDeR, a review is carried out following the death of every person with a learning disability over the age of four. The reviews offer an opportunity to identify good

		practice as well as areas where learning can be used to improve the future care of people with learning disabilities.
LGO	**Local Government and Social Care Ombudsman**	The LGO looks at individual complaints about councils, all adult social care providers (including care homes and home care agencies) and some other organisations provided local public services. Complaints about a SAR and/or any of its functions can be referred to the Local Government Ombudsman (LGO).
NMC	**Nursing and Midwifery Council**	The regulator for nursing and midwifery professionals in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses and nursing associates eligible to practice in the UK.
SAB	**Safeguarding Adults Board**	Established as statutory boards under the Care Act 2014, SABs are multi-agency partnerships of different organisations, which provide leadership and strategic oversight of adult safeguarding work for that local authority area. SABs brings together a range of partner agencies including membership from statutory partners of the local authority, CCG and policy as well as members other organisations, including community and voluntary agencies and lay members, to reflect that safeguarding activity and interventions can only be effective where there is collaboration and shared commitment.
SAEB	**Safeguarding Adults Executive Board**	The SAEB exists as the multi-agency strategic adult safeguarding partnership which covers the Bi-Borough of the City of Westminster and Royal Borough of Kensington and Chelsea.
SAR	**Safeguarding Adults Review**	One of the core duties of a SAB, under Section 44 of the Care Act 2014 is to review cases in its area where an adult with care and support needs dies or experiences serious harm as a result of abuse and neglect and there is learning as to how agencies worked together.
SACRG	**Safeguarding Adults Case Review Group**	The SACRG is one of the subgroups of the SAEB, which has responsibility for making recommendations in respect of SAR referrals and oversees the management of SARs.
SCIE	**Social Care Institute of Excellence**	SCIE is a leading values-driven improvement agency, which aims to improve the lives of all people by co-producing, sharing and supporting the use and best available knowledge and evidence about what works in health and social care practice.
SIR	**Serious Incident Reporting**	An internal process within an organisation to report serious incidents in relation to acts or omissions in care that result in unexpected or avoidable death or avoidable injury resulting in serious harm, which may threaten an organisation's ability

		to continue to deliver an acceptable standard and quality of service.
SWE	**Social Work England**	A specialist body responsible for regulating the practice of social workers in England.
TOR	**Terms of Reference**	A TOR defines the scope, aims and methodology for a SAR.

Appendix 1: SAR process flowchart

Appendix 2: SAR governance – key roles and responsibilities

Role	Responsibilities
Safeguarding Adults Executive Board (SAEB) members	• Identifying representatives from their own organisations to be involved in the SAR process. • Receiving progress reports from the SACRG regarding SAR activity. • Formally signing off final overview report. • Ensuring that action plans from SARs and other reviews are implemented and seek assurance as to how these impact on practice.
SAEB Independent Chair	• Making a decision in response to any recommendation for a SAR by the SACRG. • Ensuring the SAEB meets it statutory responsibilities and reporting on this at Board meetings. • Agreeing the methodology, scope, terms of reference and funding for the SAR.
Safeguarding Adults Case Review Group (SACRG)	• Considering all SAR referrals against the Section 44 criteria. • Making recommendations to the Independent Chair for the commissioning of SARs and other reviews. • Ensuring SARs are completed in line with the legislative framework as outlined in this SAR Protocol and Guidance. • Appointing suitable Independent Reviewers to lead the review, who should have the required level of expertise and objectivity to achieve a report of the expected standard with SMART recommendations. • Considering how the individual and / or their family can be involved within the review process and ensuring advocacy support is provided where necessary. • Obtaining legal advice for any specific elements of the review as required. • Ensuring that overview reports, together with recommendations on action plans are presented to the SAEB for approval, and regularly reporting progress to the SAEB. • Working closely with other SAEB subgroups / task and finish groups to ensure recommendations from reviews are implemented. • Ensuring that any lessons learnt from local, regional and national SARs and other reviews are shared throughout the SAEB partnership.
Safeguarding Adults Review (SAR) Panel	• Undertaking the SAR in line with the agreed terms of reference. • Considering how the interface with other reviews and parallel proceedings should be managed.

	• Ensuring that the SAR Panel has the necessary expertise to oversee and contribute to the SAR based on the specific circumstances of the case. • Ensuring appropriate involvement of professionals and agencies who worked with the individual(s) who are the subject of the SAR. • Taking account of legal advice provided in relation to any aspect of the review. • Considering how best to liaise with and involve the individual(s) and their family.
Independent Reviewer(s)	• Leading the SAR process with support from the SAR Panel and SAEB Business Manager, including contributions and facilitation of SAR Panel meetings and learning events. • Adhering to the terms of reference (TOR) of the review in terms of the scope, methodology and timescales. • Produce a report of expected standards, which shows full analysis of the circumstances of the case(s) and produces clear findings and recommendations which are SMART. • Ensure a Making Safeguarding Personal approach, and lead on meetings with the adult and / or their family / carers as part of the process. • Raise any issues of concern in relation to the process promptly with the SAEB Business Manager so as to enable effective escalation to the SAR Panel Chair / SACRG / Independent Chair.

Appendix 3: SAR referral form

Safeguarding Adults Review (SAR) Referral Form

The Safeguarding Adults Case Review Group (SACRG) of the Safeguarding Adults Executive Board (SAEB) considers every SAR referral in accordance with the SAR Protocol and Guidance and the London Multi-Agency Adult Safeguarding Policy and Procedures.

Before submitting your referral, please consult the SAR Protocol and Guidance, as well as the SAR Referrals Briefing Note.

If you feel that the SAR criteria are met and need to submit a referral, we ask that you discuss this initially with a senior manager or safeguarding lead within your organisation before submitting a referral. The referral should also be authorised by a senior manager within your organisation. You can also contact the SAEB Business Manager for consultation on referrals via the email address listed below. Please complete the referral form with as much information as possible.

The completed referral should be sent via secure email to:
makingsafeguardingpersonal@rbkc.gov.uk

SECTION 1: REFERRAL INFORMATION

DETAILS OF ADULT	
Full name of adult:	
Date of birth:	
Address:	
Ethnicity:	
Disability / care and support needs:	
Sex / gender:	

Religion / belief:	
Civil / marital status:	
Borough of ordinary residence:	
Case identifier e.g. Mosaic/RIO/Datex /CAD/ NHS number (if relevant)	
Date and place of serious incident or death:	
GP details:	
Family / next of kin / representative details (including name, address and contact details):	
Are family or next of kin aware of the SAR referral? If no, please give reason why:	
If yes, what are their views of the concern?	
How would they like to be contacted?	
DETAILS OF INDIVIDUAL / ORGANISATION MAKING SAR REFERRAL	
Referral date:	
Name:	
Role / position:	
Organisation:	
Address:	

Email:	
Contact number:	
Authorising manager:	
Role / position:	
Contact number:	
Email:	

DETAILS OF THE CASE

Brief summary of concerns which have triggered this referral:

NB: Please use plain language that can be understood by those with no prior knowledge of your agency and provide the meaning of any acronyms you use. Please do not copy and paste extensive information from your agency's records.

Please identify the type(s) of abuse relating to this case (more than one may apply):

☐ **Physical Abuse**

☐ **Neglect / Acts of Omission**

☐ **Self-Neglect**

☐ **Financial Abuse**

☐ **Domestic Abuse**

☐ **Psychological Abuse**

☐ **Sexual Abuse**

☐ **Modern Slavery**

☐ **Organisational/Institutional Abuse**

☐ **Discriminatory Abuse**

EXPLAIN HOW THE CASE MEETS THE CRITERIA FOR A SAR

Please refer to the criteria for a SAR as set out within the SAR Protocol and Guidance and explain in detail how you feel this case meets the criteria:

What are the multi-agency lessons to be learnt:

Please indicate any emerging themes:

☐ **Complex needs and multiple disadvantage**

☐ **Homelessness**

☐ **Mental capacity**

☐ **Non-engagement**

☐ **Pressure ulcers**

☐ **Suicide**

☐ **Social isolation**

☐ **Transfer of care**

☐ **Trauma**

AGENCIES INVOLVED:			
Agency	**Key contact person**	**Contact details**	**Agency informed of SAR referral?**

PARALLEL PROCESSES				
Have any other processes commenced which are looking into the circumstances of this case and/or you are aware of any that are likely to be instigated?				
Process	**Commenced**		**Planned**	
	Yes	**No**	**Yes**	**No**
Section 42 Safeguarding Adults Enquiry				
Criminal Investigation				
Coroner's Inquest				
Domestic Homicide Review (DHR)				
Mental Health Homicide Review (MHHR)				
Child Safeguarding Practice Review (CSPR)				
NHS Serious Incident (SI) Review				
Learning Disabilities Mortality LeDeR Review				
Agency Complaints Process				
Other (please state)				
Please provide additional details of any parallel processes below, including lead contact, current status of process and if completed outcomes:				

SENIOR MANAGER SUBMISSION AND AUTHORISATION OF REFERRAL

Completed by:	
Signed:	
Date:	

Please provide any supplementary documentation which could support your referral, please tick as appropriate:
☐ **Section 42 report**
☐ **Serious Incident Review**
☐ **Root Causes Analysis**
☐ **Provider internal investigation report**
☐ **Domestic Homicide Review**
☐ **Child Safeguarding Practice Review**
☐ **Learning Disabilities Mortality Review (LeDeR)**
☐ **Chronology**

SAEB USE ONLY FROM HERE ONWARDS

SECTION 2: TRAIGE BY SAEB BUSINESS MANAGER

TRIAGE INFORMATION FROM THE REFERRER	
Date referral received:	
Date contact made with the referrer:	
Summary of discussion with the referrer:	
SAR NOTIFICATION LETTERS	
Date notification letters sent to SACRG:	
TRIAGE INFORMATION FROM SUPPORTING AGENCIES (IF APPLICABLE)	
Name:	
Role / position:	
Organisation:	
Contact details:	
Date of discussion:	
Summary of discussion and agency view:	
LINKS OR SIMILARITIES WITH LOCAL OR NATIONAL REVIEWS	
TRIAGE COMPLETION	
Completed by:	
Date:	

Feedback provided to referrer?	

SECTION 3: SACRG CONSIDERATION AND RECOMMENDATION

PRESENTATION TO THE SACRG	
Name / role / agency:	
Date:	
Summary of discussion and agreed actions (usually taken from SACRG minutes):	
SACRG RECOMMENDATION	
Date:	
Recommendation and rationale for decision including: • **Confirmation as to whether a SAR is recommended and mandatory / discretionary** • **Feedback to referrer** • **Proposed methodology** • **Adult / family involvement**	

SECTION 4: SAEB INDEPENDENT CHAIR DECISION

Date of consideration:	
Comments:	
Signed:	

Appendix 4: SAR referrals briefing note

Safeguarding Adults Executive Board

Safeguarding Adults Reviews -

Referrals Briefing Note

This briefing has been produced to raise awareness of the criteria for Safeguarding Adults Reviews and to support practitioners around the key considerations when making a referral.

What is a Safeguarding Adults Review (SAR) and what difference do they make to safeguarding?

A SAR is a multi-agency review to determine what agencies involved could have done differently that could have prevented harm or death from taking place.

It is important to note that the aim of a SAR is not to apportion blame – it is to promote effective learning and improvement to prevent future deaths or harm occurring and to improve how agencies work together to supporting adults with care and support needs, and their families, to achieve positive outcomes.

SARs are important because the findings and recommendations are used to drive forward improvements to services across the safeguarding partnership and the learning is used to support continuous development.

When is a SAR required?

The Safeguarding Adults Case Review Group (SACRG) is a subgroup of the Safeguarding Adults Executive Board (SAEB) which has delegated responsibility for making decisions on SAR referrals and for overseeing SARs as well as monitoring progress of learning actions and improvements to systems, procedures and practice which arise from such reviews.

Cases should be referred to the SACRG for consideration for any case in which it appears the criteria for a SAR are met.

Section 44 of the Care Act 2013 and the accompanying Care and Support Statutory Guidance sets out that Safeguarding Adults Boards (SABs) have a mandatory duty to carry out a SAR when:

- An adult in its area dies as a result of abuse or neglect, whether known or suspected;
  or
- Where the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect;
  and
- There is concern that partner agencies could have worked together more effectively to protect the adult.

The Care Act also states that SABs can arrange for a SAR to be commissioned in any other situation where the criteria are not met, but it is clear that there are valuable lessons to be learnt with the aim of improving how agencies work together to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future. This is known as a discretionary SAR.

Who can make a referral for a SAR?

Any professional or agency representative can make a referral for consideration of a SAR for any case in which they believe the criteria above are met by completing the completing the SAR referral form.

If a member of the public wishes to raise a SAR referral, they should approach the SAEB Business Manager or SAEB partner agency to discuss further. It will be the responsibility of that body to identify the most appropriate route to take this request forward. This may result in a SAEB partner agency completing a SAR referral form on behalf of the member of the public or may also involve advising them why the request does not meet the criteria for a SAR and that it would not be appropriate to raise this.

Referrals should be sent via secure email to: makingsafeguardingpersonal@rbkc.gov.uk

What are the key considerations when making a referral?

When making a referral please ensure the following points are considered:

(1) You understand what a SAR is and consider the Section 44 criteria:

- What is the abuse or neglect that has contributed to the death or caused serious harm?
- Did or does the adult have care and support needs?
- Is there an indication for multi-agency learning?
- Are there any other current processes taking place – such as a safeguarding enquiry, police investigation or coroner's inquest?

(2) You discuss the referral with a senior manager / safeguarding lead:

- Confirm that you are satisfied that the criteria are indicated and can evidence this within the referral.

- If there was a view that multi-agency working was problematic, it is good practice to ensure that discussion has taken place with partner agencies affected so that the referral process is transparent and where possible sent in on the basis of a consensus of what the issues in the case were.

(3) Consider contacting the SAEB Business Manager:

- If you have any queries or require further consultation, contact the SAEB Business Manager via details at the end of this briefing.

(4) Complete the SAR referral form:

- Complete as fully and with as much detail as possible.
- Provide a clear rationale as to how you feel the criteria are met.
- Where other internal investigations or reviews have taken place, such as a Section 42 enquiry or Root Cause Analysis, please provide copies of reports and / or an overview of the learning, recommendations and actions already taken forward.

What happens next?

The referral will be triaged by the SAEB Business Manager who may contact you for further information and discussion.

If the referral clearly does not meet the criteria or has been submitted inappropriately in place of a safeguarding concern, the referrer will be signposted to the safeguarding referral pathway.

The Safeguarding Adults Case Review Group (SACRG) of the Safeguarding Adults Executive Board (SAEB) meets every six weeks and considers every SAR referral in accordance with the SAEB SAR Protocol and Guidance, the London Multi-Agency Adult Safeguarding Policy and Procedures and the SCIE SAR Quality Markers. The Quality Markers provide a checklist to support good practice in the SAR process and to ensure the approach is consistent and robust.

The professional who has made the SAR referral will be invited to a SACRG meeting to present the referral and contribute to the discussion and decision making on the case. The presentation should concentrate on how the criteria are met, and consideration of what learning there is for multi-agency systems and processes - not on apportioning blame.

The SACRG will make a recommendation to the SAEB Independent Chair, who makes a final decision on whether to commission a SAR. The decision-making process will include consideration of the best approach to achieve the maximum learning in each case, and the best way to involve the adult and/or their family/friends/carers in the review process. If the referral does not meet the SAR criteria, a discretionary review or another course of action may be taken instead, for example a Single Agency Review.

Questions to consider and discuss

- Are you aware of the SAR criteria and do you feel confident in raising SAR referrals?
- Do you know what action to take if you have a case that might meet the SAR criteria?
- What further support or training do you think you / your team need?

Further information and useful resources

For any further information please contact Trish McMahon, SAEB Business Manager at makingsafeguardinpersonal@rbkc.gov.uk

SAR Protocol and Guidance

SAR Referral Form

SAR Guide for Families and Carers

London Multi-Agency Adult Safeguarding Policy and Procedures

National Analysis of SARs

SCIE Guidance on SARs

SCIE SAR Quality Markers

SCIE: User involvement in adult safeguarding

SCIE: Safeguarding adults and sharing information

Appendix 5: Summary of involvement form

Safeguarding Adults Executive Board

The information requested on this form will be used for the initial scoping out of information for any referral for a Safeguarding Adults Review (SAR).

The form is sent out to all relevant agencies, you are asked to complete only those questions on which you hold information or indicate that this person and their family were not known to your services.

This pro-forma should be completed by the **Lead Safeguarding Adult's professional in your organisation** or equivalent and returned to makingsafeguardingpersonal@rbkc.gov.uk

Details of the adult (to be completed by the SAEB)	
Name:	
Date of birth:	
Date of death (if applicable):	
Address:	
NHS / Mosaic ID numbers:	

Agency information (to be completed by the agency)	
Name of agency:	
Name of person completing the report:	
Job Title:	
Contact number:	
Email address:	
Date when your involvement with the adult started:	

Date when your involvement with the adult ceased and why:	
Scope of information requested	1. Whether this adult, members of their household or other significant people are/were known to your agency. 2. If known to your agency please provide a brief overview of the last 6-12 months or other relevant information

Date:	**Summary of involvement** *(Please record a brief overview of your organisational involvement in the timeframe requested. This is not a request for a chronology of events)*
Please summarise below in a paragraph or two below, how your agency has been involved with the person during the time period under review. *e.g. Mr X has been known to our service since DATE and was last seen by our service on DATE* • Medical / Disability / care and support needs • Brief description of the nature and frequency of your involvement.	
Please detail any significant information that falls outside the timeframe requested below ***(i.e.*** *if your agency had involvement with the person* ***before*** *the period under review, please summarise it here, in a paragraph or two)*	

Declaration: I confirm that this is an accurate Summary of Involvement and that the information requested has been passed to relevant senior managers prior to returning to the SAEB.

Name:	
Role:	
Date:	

Appendix 6: SAR Terms of Reference template

Safeguarding Adults Review Terms of Reference (TOR)

1. General considerations

Under section 44 of the Care Act 2014 the Safeguarding Adults Executive Board (SAEB) has a statutory duty to arrange a Safeguarding Adult Review (SAR) where:

(a) an adult with care and support needs has died as a result of abuse or neglect, whether known or suspected, or an adult is still alive, and the SAEB knows or suspects that they have experienced serious abuse or neglect, and

(b) there is concern that partner agencies could have worked together more effectively to protect the adult.

If the SAR criteria are not met but the SAB feels that there is multi-agency learning to be gained from the case(s), a discretionary review may be commissioned.

Board partners must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect and are unable to protect themselves.

SARs are carried out in accordance with the Safeguarding Adults Case Review Group (SACRG) protocol of the SAEB and will follow the SAR Quality Markers. All reviews should include consideration of how race, culture, ethnicity and other protected characteristics as set out in the Equality Act 2010 may have impacted in the management of the case(s) under review.

2. Outline of cases and SAR referrals
3. Rationale and recommendation for a SAR
4. Specific terms of reference and areas of learning

Outline key lines of enquiry

All reviews should include:

- Where good practice can be identified in these cases.
- A review of service improvements undertaken since these deaths and evaluation of the success and impact of these changes.
- Recommendations for further systems improvements required to improve the quality of services to adults with care and support needs where there are fire risks.

5. Scope and methodology

To include details of all stages of the review process, timescales, supporting documents etc

6. SAR panel membership

Agencies that were involved within the case will be asked to contribute to this review and attend SAR panel meetings.

SAR panel members will be identified from the following agencies:

It is critical to the effectiveness of the thematic review process that the correct management representatives attend any scheduled events and meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge. They should not have had any direct involvement in the case or supervision of those professionals that were.

Each SAR panel meetings will review a timetable and action planning document, for which it is the responsibility of the Independent Reviewer to update and present at each meeting. The Independent Reviewer will need to work closely with the SAEB Manager to ensure agencies have returned information in a timely may and any escalations can be progressed promptly to ensure panel meetings are productive.

The SAEB has appointed X as the Independent Reviewer.

7. Governance and sign off procedures

In terms of governance:

- The operational progress of the review will be managed through the SAR Panel meetings.
- The SAEB Business Support Team will provide all administrative support.
- Progress of the review will be reported into the SACRG, where the draft report will be presented and agreed, before sign-off at the SAEB.
- The SACRG will also support the development of an action plan.
- The final version of the report and action plan will be presented to the SAEB for sign off.

If there is challenge to the report findings and or recommendations then it is hoped that the independent reviewer will identify any areas early on in the process and through the various interfaces come to a mutual agreement across all agencies involved .If however this is not possible and there remains disagreement with the facts or interpretation of the report then the agency who is unable to sign off the report submits a response on the areas of concern and this is then noted as an appendix.

8. Links to other reviews or processes

A SAR will ordinarily only be considered following the conclusion of a statutory (i.e.. Police, Local Authority or NHS) enquiry or investigation (e.g. police criminal investigation, section 42 safeguarding enquiry or SI review). However, on occasion, there may be situations where enquiries or investigations have not been completed, but the circumstances of the case necessitate that a SAR should commence in parallel to the other investigatory process. Decisions as to the need for and the appropriateness of this will be made on a case-by-case basis.

All reviews should consider any parallel processes or reviews that have taken place and the learning from them.

9. Involvement of the adult(s) and their families / carers

In line with Making Safeguarding Personal, the consideration will be given from the outset of the review as to the most appropriate way of enabling involvement of the adults (in non-fatal cases) or families of the deceased to have an opportunity to contribute to the review.

The SAEB Business Manager will contact the next of kin / family members to inform them that a review is taking place, and to offer them an opportunity to contribute and be involved in the review. Should the family wish to be involved, the Business Manager will arrange for the Independent Reviewer to meet with the family.

The draft overview report will only be shared with the family via a face-to-face meeting, and only once the report is made public will it be shared with the family electronically or by post.

10. Legal Advice

Legal advice will be sought from the Bi-Borough Legal Team as required. In the event of the report being submitted as part of judicial processes, there would be an expectation that the Independent Reviewer will need to attend Court to present. The Reviewer would be supported by the Bi-Borough legal team and the SAR Panel.

11. Media strategy and publication

At the end of the review a media strategy meeting will be held to consider publication of the overview report, which will involve all relevant media / communication leads across the agencies involved and a coordinated press statement will be prepared.

All agencies involved in the review should alert their media / communications officers of the review at the point the report is signed off by the SAEB. If there are any media requests, agencies will direct these to the SAR Panel Chair and SAEB Business Manager who will direct these to the press officer in the Bi-Borough Communications Teams.

The SAEB is responsible for the handling of the report and for all feedback to staff, family members/friends and the media.

12. Confidentiality, information sharing and General Data Protection Regulations (GDPR)

All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this thematic review and for the secure retention and disposal of that information in a confidential manner.

All communication regarding this SAR that contains personal and/or sensitive information must be sent securely using secure email addresses.

Under the General Data Protection Regulation (Regulation [EU] 2016/679), the SAEB has an Article 6 lawful basis for processing under 1(c) [Legal Obligation] and an Article 9 lawful basis

under 2(g) [Substantial Public Interest]. This concurs with practice elsewhere in the country. Some boards also chose to employ Article 9(h) instead.

The article 6 legal obligation is conferred by Section 45 of the Care Act 2014.

13. Review of TOR

This TOR will be subject to review in light of new information that may become apparent. Amendments must be approved by the SAR Panel.

Appendix 7: Guidance for SAR panel members

Safeguarding Adults Executive Board

Guidance for Safeguarding Adults Review (SAR) Panel Members

What is a Safeguarding Adults Review (SAR)?

A SAR is a multi-agency learning process. The purpose of a SAR is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

Safeguarding Adults Boards (SABs) have a statutory responsibility to consider arranging a SAR when there is concern that partner agencies could have worked together more effectively to protect an adult with care and support needs from abuse or neglect.

SARs seek to establish:

- Lessons that can be learnt to apply to future cases and prevent similar harm from re-occurring
- How effective safeguarding procedures are
- Good practice as well as learning from what went wrong
- Service and systems improvements to inter-agency practice.

It is important to note that a SAR is not an enquiry into the cause of death or injury. It does not seek to apportion blame or punish anyone involved and is separate to any investigation undertaken by the police or Coroner or via a complaints process.

What is a SAR Panel?

As a SAR Panel member, you will be invited as a senior manager from your agency to attend a number of meetings, which will be chaired by a nominated SAR Panel Chair (whose agency has not been directly involved in the case) or the Independent Reviewer. SAR Panel meetings involve senior representatives from all the relevant agencies who were involved in the case(s).

Given your agency's involvement in the case(s), it is important to have your contributions to the review process. This also provides an opportunity for you to fully share your agency's knowledge, view and experience of working with the adult(s) who are the subject(s) of the SAR as well as ensuring factually accurate information about your agency's involvement.

The first SAR Panel meeting enables members to consider the terms of reference (TOR) for the review, to discuss what information will be required from agencies to support the process and to ask any questions of the Independent Reviewer, who is responsible for leading the review process and producing an overview report with findings and recommendations.

The final SAR Panel meeting will be an opportunity for members of the panel to review the draft report and provide comments on the findings and recommendations and if necessary, highlight any issues relating to factual accuracy.

You will be sent an agenda and any papers approximately a week in advance of any SAR Panel meeting.

What is expected of SAR Panel members?

Best practice is to complete a SAR in a timely manner with the aim of completion in six months. As a SAR Panel member, you are expected to commit to the timescales set out within the TOR to ensure the review can progress effectively and in line with the principle of no delay.

In your role as a SAR panel member, you are expected to:

- Prioritise attendance at all SAR Panel meetings. If you are unable to attend, please delegate responsibility to another suitable representative from within your agency.
- Be accountable for agreeing to the TOR.
- Be responsible for completion of any reports to support the SAR, such as Summary of Involvement (SOI) reports or Individual Management Reviews (IMR).
- Contribute to discussions in meetings and provide feedback and information on behalf of your agency.
- Respond to communications from the Safeguarding Adults Executive Board (SAEB) and Independent Reviewer(s) and act as a channel of communication between the SAEB and your own agency.
- Take forward any agreed actions/recommendations as a result of the SAR and feed these back to the SAEB within timescales set.

What should you expect of the SAR report?

SAR overview reports should:

- Be written in plain English and be fully checked for spelling, grammar and formatting.
- Not use emotive, inflammatory, blaming/shaming language or identify specific staff or identifiable teams within agencies.
- Where abbreviations or acronyms are used these should be explained in full in the first instance.
- Be written from a Making Safeguarding Personal perspective, ensuring the adult(s) is the focus of the review and recording their views and wishes where these are known.
- Be balanced and focused on facts, sound analysis and conclusions and produce recommendations which are SMART (Specific, Measurable, Achievable, Realistic and Timely).

Further information and useful resources

For any further information please contact the SAEB Team at makingsafeguardinpersonal@rbkc.gov.uk

SAR Protocol and Guidance

London Multi-Agency Adult Safeguarding Policy and Procedures

SAR Family-and-Friends-Leaflet.pdf (saeb.org.uk)

Appendix 8: Individual Management Review (IMR) template

Strictly Confidential

Safeguarding Adults Executive Board

SAFEGUARDING ADULTS REVIEW (SAR)
INDIVIDUAL MANAGEMENT REVIEW

COMPLETED BY

NAME OF AGENCY

NAME OF ADULT

D.O.B:

Time period for the SAR:

Please provide any further significant information prior to x

Details of person completing the IMR and Chronology:	
Name:	
Contact Details:	Email: Telephone number:
Post held:	

Date of request for IMR	
Date of completion of IMR	

INDIVIDUAL MANAGEMENT REVIEWS

18. 1. Introduction

1.1 This document is intended to provide an individual management review of the decisions, actions taken and services provided to XXXXXXX who is subject of a Safeguarding Adults Review (SAR) instigated by the Safeguarding Adults Board (SAB). The SAR Panel requested an IMR for return by the XXXXXX

1.2 The aim of the individual management review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

1.3 The individual management review provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the adult with care and support needs.

1.4 The IMR author should be able to:

- gather and analyse information,
- clearly describe what happened, commenting on the quality of practice
- provide explanations for why it happened
- clearly show how the conclusions relate to the individual case as well as the wider safeguarding practice within the organisation.

2. METHODOLOGY

List the sources of information that your agency has used to compile your report. This might include paper records, IT systems searched, computer records, supervision notes etc. It should also include some details about staff that have been interviewed as part of this review, or if not why not? Please say if files could not be found and why.

3. FACTUAL/CONTEXTUAL SUMMARY

Provide a brief factual and contextual summary of your agency's involvement with this case for the time period identified for this safeguarding adult review.

5. ANALYSIS OF INVOLVEMENT

The report author is expected to rigorously analyse the involvement of their agency, consider the events that occurred, the decisions made and the actions taken or not. See Appendix 0: Guidance for the Completion of IMRs.

6. CRITICAL ANALYSIS

In this section the IMR author must answer the questions below which are taken directly from the Terms of Reference. Take time to reflect on the information you have provided in the chronology. The information provided and the analysis should be appropriately evidenced/explained fully.

Please ensure to clearly specify if any of the questions are not relevant to your agency and/or service and the reasons why. If a question is left blank, it could be queried by the SAR Author.

6.1 Learning for all agencies around assessing risk

6.2 Roles and responsibilities, opportunities for proactive joint working.

6.3 Managing high risk cases in the community – multi agency support/protection plans and contingency plans.

6.4 Mental Health and Self Neglect – approaches to long term planning.

6.5 To consider looking at structures and processes.

7. WHAT DO WE LEARN FROM THIS CASE?

Following on from the critical analysis section previously, the IMR author should identify specific lessons which his/her agency can learn from the case. These can include areas of good or poor practice identified, as well as ways in which practice can be improved.

8. RECOMMENDATIONS FOR ACTION

Any recommendation about improving or developing new procedures should be specified in terms of the expected practice outcomes. Actions contained in this IMR report will be considered by the SAR Panel for inclusion in the SAR Report. The SAR Panel may also recommend further actions for your agency to be included in the SAR Report. You should add as many actions for your agency as is necessary.

Glossary of Personnel involved

Name	Job Role	Identification in report

APPENDIX 9: Guidance for the Completion of Individual Management Reviews [IMR]

ANALYSIS OF INVOLVEMENT

The Terms of Reference should be referred to as headings to analyse practice against and facts should not be stated without their origin. Consider specifically the following questions:

- Were practitioners aware of and sensitive to the needs of the adult in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about an adult with care and support needs' welfare?

- When, and in what way, were the adult's wishes and feelings ascertained and taken account of when making decisions about the provision of the adult's services? Was this information recorded?

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of adults with care and support needs and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult and their family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

- Where relevant, were appropriate Safeguarding Adult's or care plans in place, and the reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the adult and their family, and were they explored and recorded?

- Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Was the work in this case consistent with each organisation's and the policy and procedures for safeguarding and promoting the welfare of adults with care and support needs and with wider professional standards?

- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations?

- Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

APPENDIX 10 – Chronology of Involvement

Time period for the SAR:

Please provide any further significant information prior to x

Details of person completing the Chronology:	
Name:	
Contact Details:	Email: Telephone number:
Post held:	

Date of request:	
Date of completion:	

HISTORICAL CONTEXT OF AGENCY INFORMATION (NARRATIVE SUMMARY)

If your agency had involvement with the person before the period under review, please summarise it here, in a paragraph or two.

Please use the table below to document your agency's involvement over the period under review.

Please detail names and roles of key staff involved in the entry. Please do not anonymise this chronology.

Please distinguish:

- **Contact / communication <u>to you</u> about this case from other agencies/partners**
- **Contact / communication <u>from you</u> to other agencies /partners about this case**
- **Other responses / activity / interventions – including internal communication, planning, chasing as well as actual interventions that may have occurred**

The last column should be used for **comment or questions about**

a) **the rationale for actions/decisions and**
b) **views on the appropriateness and quality of activity/response**

Your Agency	**Date (from)**	**Date (to)** if relevant	**Description of agency activity/contact/communication received or made:** **Please detail names and roles of key staff involved in the entry**	Source of evidence	**Comment or questions about the rationale for actions/decisions and views on the appropriateness and quality of activity/response**

Appendix 11: Learning briefing feedback form

Learning Briefing Feedback Form	
Sharing Learning is a key priority of the Safeguarding Adults Executive Board (SAEB) and ensures that lessons in relation to safeguarding adults supports direct practice and encourages a culture of continuous improvement. **Please complete this form to confirm that the learning outcomes within this learning briefing have been considered by your team and how the learning will inform practice.** **Please send completed forms to makingsafeguardingpersonal@rbkc.gov.uk**	
Please describe how the learning outcomes included in this briefing have been communicated to staff in your team. For example, a specific learning event, team meeting or any other method.	
Please describe any changes to practice that has been or will be implemented as a result of the learning highlighted in this briefing.	
How will the effectiveness of these changes be measured or monitored?	
The SAEB welcomes feedback from frontline staff, senior management and those with governance responsibilities. Please provide any additional thoughts, feedback and comments on the learning presented within this briefing.	
Manager name	
Job Title	
Organisation/department	
Contact details	