Barnet Safeguarding Adults Board
Safeguarding Adults Reviews

Safeguarding is everyone's business

A Local Protocol for Requesting and Conducting a Safeguarding Adult Review in accordance with Section 44 Care Act 2014

Version 4	
Last Reviewed	January 2020
Next Review	January 2022

CONTENTS

Acknowledgements and context

This document should be read in conjunction with the Pan London Multiagency Safeguarding Adults Protocol, the Care Act and the statutory guidance accompanying the Care Act.

The SAB would like to thank, acknowledge and recognise the work of the Hackney Safeguarding Adults Board as a major source for the revision of this protocol and its content.

1. INTRODUCTION

1.1 Section 44 of the Care Act 2014[1], requires that Safeguarding Adult Boards (SAB) are responsible for Safeguarding Adult Reviews (SAR). Paragraphs 14.162 to 14.179 of the Care and Support Statutory Guidance[2] sets out in more detail the principles, definitions and outlines a framework for when certain events happen.

1.2 The SAB must arrange a SAR when an adult in its area dies 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. The SAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

1.3 The SAB is free to arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

1.4 The adult who is the subject of the SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them. If they are able and chose to, they should be fully involved throughout the process (see Section 10 below).

1.5 This SAR Protocol has been developed by the Barnet Safeguarding Adults Board (BSAB) in order to support the effective identification of and response to SARs within the Borough and to support the Board in discharging its statutory duty. The Protocol describes the process to follow, and is informed by the statutory text and complements the Pan London Safeguarding Policy

1.6 It is important to stress that a SAR is not a 'second stage' safeguarding process and is used to identify significant systematic barriers to effective safeguarding practice.

2. SAFEGUARDING ADULT REVIEW OPERATING FRAMEWORK AND GOVERNANCE

2.1 The SAB has the legal responsibility to commission a Safeguarding Adult Review (SAR) where the criteria is met.

2.2 The SAB has delegated management of this responsibility to the Case Review Sub-Group (hereafter referred to as the "Sub-Group") chaired by a Member of the BSAB, but retains responsibility for determining whether to commission a SAR, determining arrangements for the publication and monitoring

[1] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
[2] https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding

implementation of any action plan arising from the SAR. The Sub-Group membership is made up of the statutory and non-statutory members of the SAB, with specific a Terms of Reference that is reviewed annually. It reports to the SAB. The Sub-Group will adopt the SAR Quality Indicators as a framework to ensure the delivery of high quality SARs.

2.3 The Sub-Group meets on a planned basis throughout the year. Decisions can also be made via an email discussion.

2.4 If a relevant party, i.e. someone affected by the decision, does not agree with the decision of the SAR subgroup not to progress the case, they can request a review of this decision by writing to the Independent Chair of the SAB. The relevant party will have 28 days to submit an request. The Chair will have a further 28 days to review the case and respond in line with the procedure detailed a 6.5 of this protocol.

2.5 The Subgroup and the Chair of the Board can access legal advice from the Council's legal services and may at times request independent legal advice.

3. PURPOSE OF A SAFEGUARDING ADULT REVIEW

3.1 The purpose of a SAR is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard vulnerable adults.
- Review the effectiveness of procedures and their application (both multi-agency and those of individual organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

3.2 It is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

3.3 It is not an alternative to a safeguarding enquiry, investigation or process.
It is acknowledged that there may be processes such as the LeDeR process or internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these, but it remains a statutory requirement in its own right and will be complemented by other such processes.

3.4 There may be cases where other legal and non-legal review processes may be activated (e.g. Domestic Homicide Review, Child Serious Case Review, Mental Health Homicide Review). The SAB should liaise with the relevant Boards and agencies to ensure that a joint decision is made with regards to who is responsible for leading the review. There should also be agreement on the following:

- How the legal elements from each review will be incorporated in the review
- How the review will be conducted and who will Chair the process
- What is contained in the terms of reference
- The final report and its findings and recommendations

4. CRITERIA FOR SAFEGUARDING ADULT REVIEW

4.1 In summary, the SAB has the lead responsibility for arranging and conducting a SAR and **must** do so when:

- An adult in its area dies 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.
- If the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

4.2 "*Serious abuse or neglect*" may include where:

- the individual would have been likely to have died but for an intervention.
- the individual suffered permanent harm as a result of abuse or neglect.
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect;
- the individual has sustained a potentially life threatening injury through abuse or neglect,

4.4 The SAB **may** also consider a SAR in other specific circumstances outside of the statutory requirement, including where, for example:

- A case featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

4.5 Anyone can refer a case for consideration, but it is envisaged that practitioners working across voluntary and statutory agencies, including Coroners, will be expected to refer cases an adult(s) at risk has died or suffered serious harm, abuse or neglect contributed to the death or serious injury and there is reasonable cause

for concern about how SAB partner agencies or persons with relevant functions worked together to safeguard the adult. For example, this may include:

- Suicide
- Domestic Homicide
- Homicide- where there is reasonable cause to suspect the victim or alleged perpetrator is an adult with care and support needs
- Unexpected death of an adult in receipt of formal care (including in the client's own home)
- A serious incident (such as a fire in a care home or sexual assault in a regulated setting)
- A near miss (where medical intervention was required to prevent serious harm to an adult at risk and risk management is required to prevent the incident occurring again)

5. REQUESTING THAT A SAFEGUARDING ADULT REVIEW BE UNDERTAKEN (REFERRAL)

5.1 Any agency, professional or member of the public may consider that a case meets the criteria for a SAR and request that one be undertaken. The prospective referrer is encouraged to secure approval from senior leaders/ designated safeguarding leads within their own organisation and to discuss the concern with Council's Head of Safeguarding, or CCG's Director of Quality /Safeguarding Lead to assess whether the criteria in Section 4 is fully considered before making any referral.

5.2 It is important to note the BSAB will only consider cases *"in it's area"* as per Section 44 of The Care Act. In practice this means it will consider cases which relate to people residing within Barnet (which includes people who have been placed by other Boroughs or Clinical Commissioning Groups into the area). Should a person placed by Barnet Clinical Commissioning Group or Barnet Council in another area be the subject of circumstances that would be a SAR, then it would be for the SAB of that locality to carry out and oversee a SAR.

5.3 The formal referral to the SAB should be made to the Barnet Safeguarding Adults Board's Board Manager on the form [Appendix A], and should include details of the case, agencies involved and reasons for making a referral to the SAR sub-group.

5.4 Upon receipt of a SAR referral the Board Manager, if necessary in consultation with the SAB Independent Chair or Chair of the Sub-Group will review the information against the criteria and will write to relevant partner agencies involved in the case for further information to enable full consideration the case at the next Sub Group meeting. Consideration will also be given to how best to inform the adult or their representatives/family members of the process and how they may wish to be involved.

5.5 In deciding whether a referral should progress to a SAR, the Sub Group will invite relevant parties to the Sub Group meeting to enable the Sub Group to clarify matters as required. There should be consideration given to offering parties the additional support if required.

5.6 In all cases the SAR Sub Group should seek to establish whether the matter is also subject of a police investigation, judicial or coronial investigation. If the case is, the Sub Group should speak to the relevant persons to ensure that it appropriate for the Board to procced with the SAR at that stage. If a SAR report has been completed without the judicial or coronial process being finalised, the Sub Group should speak to the relevant persons before publishing the report.

5.7 Equally where an issue triggers a mandatory investigation or review within an organisation (e.g. NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. In all such cases, legal advice may be appropriate to guide the decision-making.

6. DECIDING TO UNDERTAKE A SAFEGUARDING ADULT REVIEW

6.1 The Sub-Group remains responsible to the SAB. The Safeguarding Adults Board has ultimate responsibility for deciding whether or not to conduct a SAR.

6.2 In deciding if a SAR should be undertaken, the Sub Group can refer to the flow chart on page 11 and the supporting information on SAR methodologies. Outcomes should be recorded by the Board Manager on the recommendation form.

6.3 The Chair of the Sub Group will notify the SAB Chair and the DASS of the recommendation. This will tabled for discussion and decision at the next SAB and minutes of any deliberations recorded.

6.4 The referrer and all relevant parties should be notified of the SAB's decision by letter from the Chair of the Sub-Group, within 28 days of the SAB meeting. If the SAR is not to proceed, then the letter should outline the reasons for the decision.

6.5 If any relevant party is not happy with the decision they are able to make further representations to the Independent Chair who will determine whether the decision should be reviewed or overturned. Within 28 days of a request being received, the Independent Chair should write to relevant parties, setting out their rationale following their review of the request. If the review is not successful the party should be notified that they can make a complaint to the Local Government Ombudsmen. Further details can be found: https://www.adass.org.uk/media/4104/cpf-26-150203-safeguarding-adults-boards.pdf

6.8 All such decisions and actions, including those that are taken by the Sub Group or a convened SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability – see Care Act Statutory Guidance and London Multi-Agency Safeguarding Adults Policy and Procedures for more details).

7. CONSIDERATIONS

7.1 Once it has been agreed to commission a SAR, the most appropriate methodology to use should be considered. Different methodologies will suit different types of circumstances. These can range from facilitated learning events over a day or two, through to formal panel-led over-arching type of enquiries carried out over a period of time. The choice of methodology is therefore significant and must be appropriate and proportionate to the case under review. The Care and Support Statutory guidance indicates that, whichever methodology is employed, the following elements should feature:

(A) **SAR Panel Chair/ Lead/ Facilitator,** that is independent of the case under review and of the organisations whose actions are being reviewed. They should have the appropriate skills, knowledge and experience, which will include:

- Strong leadership and ability to motivate others
- Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
- Good analytical skills using qualitative data
- A participative and collaborative approach to problem solving
- Adult safeguarding knowledge and experience
- Commitment to/ promotion of open and reflective learning cultures.

(B) **SAR Panel of relevant and nominated people** who will contribute to and scrutinise information submitted, in the form agreed. The panel size should be proportionate to the nature and complexity of the review.

(C) Clear **Terms of Reference,** setting out what is the focus and scope of the SAR (and where appropriate, what is not within scope); times frame within which the SAR will focus; roles and expectations and outcomes required.

(D) **Early discussions with the adult and their family/ carers** to explain the purpose and process of the SAR, agree to what extent, how they wish to be involved and to manage expectations. This includes access to independent advocacy if required. This process may involve identifying a next-of-kin and appropriate efforts should be made to liaise with the appropriate persons (See Section 10)

(E) **Appropriate involvement of professionals and organisations who were working with the adult** so they can contribute their perspectives without fear of being blamed for actions they took in good faith (See Section 11)

(F) **A final report and recommendations,** which effectively sets out the specific and wider learning considerations

(G) **An action planning session,** to help relevant agencies identify achievable actions to be taken from the report.

(H) **A briefing for staff** on key learning points

7.2 Whatever methodology used it must be proportionate to the specific circumstances of the individual case. It should provide the most effective learning mechanism and best enable the involvement of key agencies and staff as well as those who are connected to the person (e.g. family etc.) and achieve the outcome required.

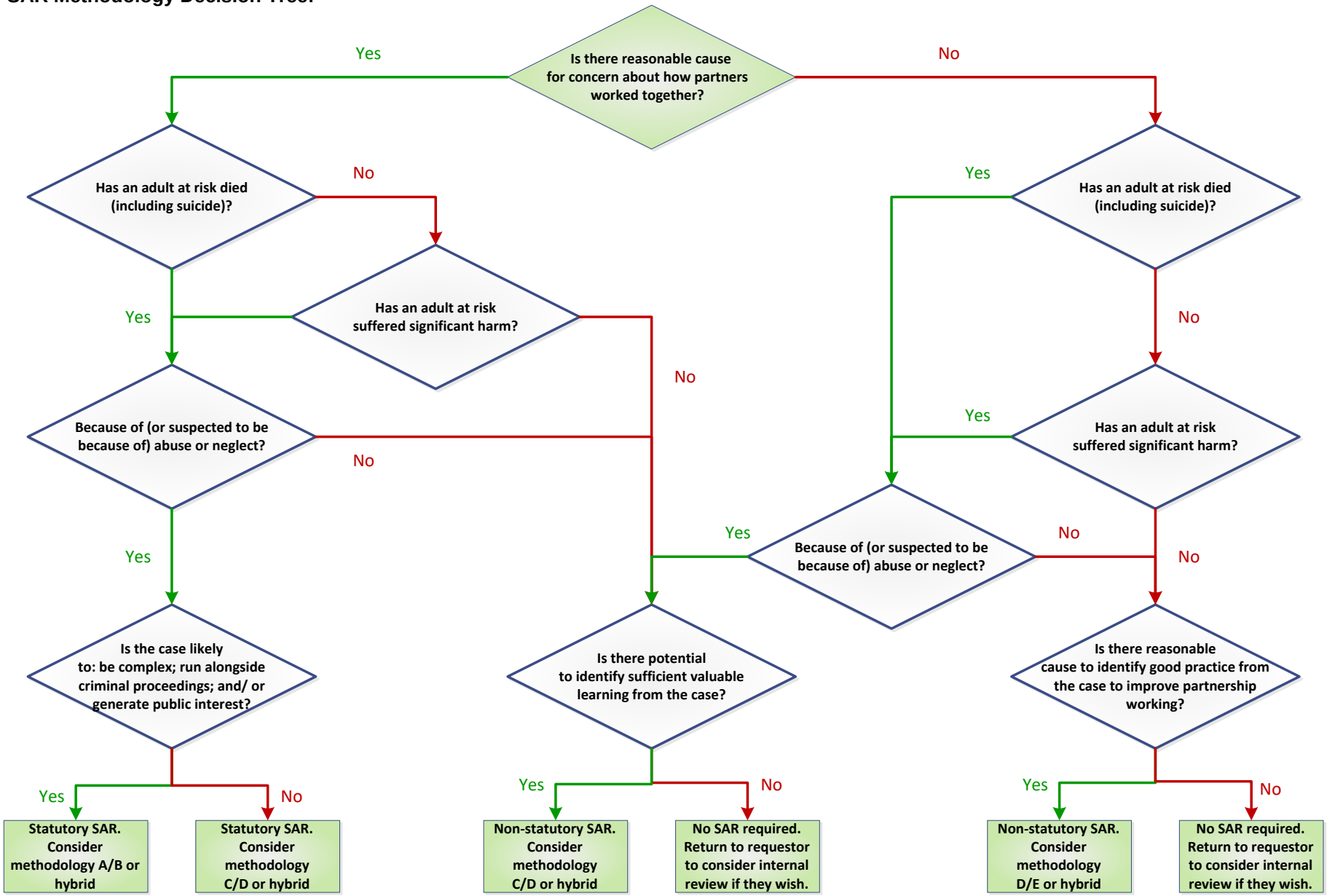
7.3 Each methodology is valid in its own right and no approach should be perceived as more significant or holding more importance or value than another. In deciding upon a methodology the SAR subgroup should consider the following key determinants:

- Is the case complex, involving multiple abuse types and/ or victims?
- Is significant public interest in the review anticipated?
- What level of staff/ family involvement is wanted/ appropriate?
- Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of methodology being proposed proportionate to the scale and level of complexity of the issues being examined?
- Will it achieve the objective of the SAR?
- What will be the essential criteria that the Reviewer will have to meet to carry out the SAR?

7.4 Other Considerations for the SAR subgroup

- Are other legal reviews being activated i.e. SCR, DHR, or Serious Incident Investigations etc.
- Who is most appropriate to chair the Panel?
- Who will contact the family?

SAR Methodology Decision Tree:



8 DIFFERENT METHODOLOGY OPTIONS AND CONSIDERATIONS FOR A SAFEGUARDING ADULT REVIEW

8.1 The suggested different types of methodologies that could be utilised are set out below. This is not a prescriptive or exhaustive list but offers a range of options that could be matched to different presenting circumstances. Alternatives, based upon the collective experience of the Sub Group and SAB should also be considered as appropriate.

8.2 When a referral is considered by the Sub Group, they should also consider the most appropriate methodology and include this in any recommendation about the SAR's merits to the SAB.

8.3 There are broad considerations prior to initiating a SAR. These issues will be considered when drafting the terms of reference. These include, but are not limited to:

- The level of independence that is required of people who will be involved in the SAR (and who may be possible Panel Members and who may be involved in writing any reports or developing any agency analysis for the process);
- Level of independence required of the SAR Chair (e.g. representative from another agency, external consultant etc.)
- The broad Terms of Reference for the SAR including timescales for completion and how learning from the SAR will be disseminated and embedded
- The objective of the SAR.

The list below outlines different types of methodology use in SARs. The SAR subgroup is not limited to selecting a methodology from the list.

`

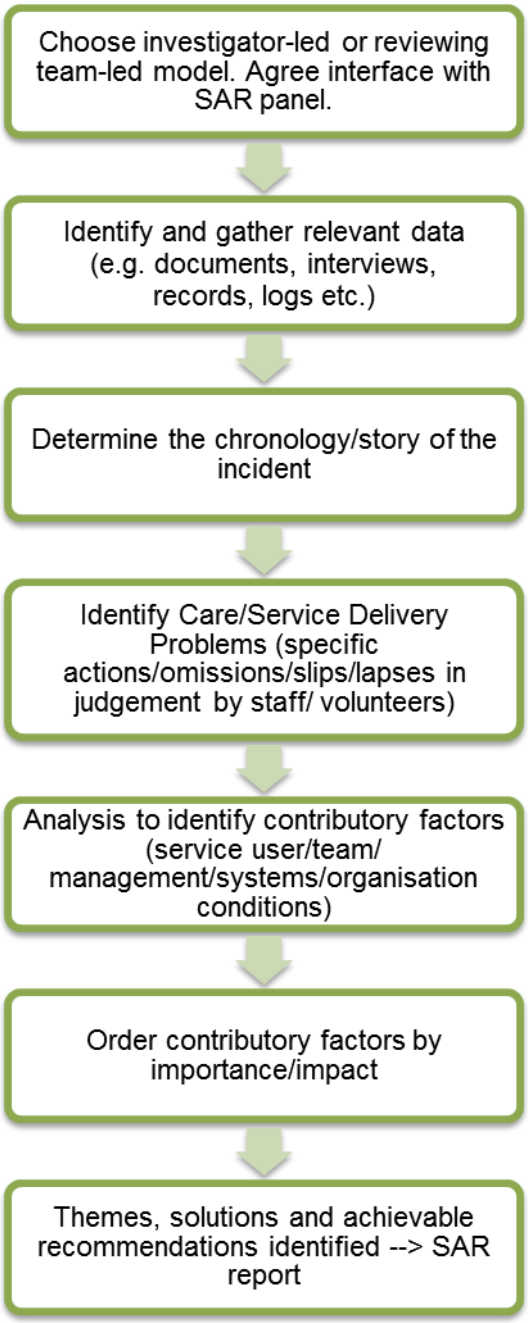
OPTION A: Traditional SCR Approach

Key features:

- ✓ Independent Chair/Author
- ✓ Formal panel
- ✓ Single agency Individual Management Reports (IMRs) Individual and Integrated chronology
- ✓ Staff/ adult/ family involved as agreed
- ✓ Provides analysis of what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
• More familiar to SAB/stakeholders, who may consider it more robust/objective • Brings a strong level of independence and scrutiny • Public/political confidence is more likely to be assured via a tried and tested approach • Particularly useful where there is multiple abuse, or high profile cases/serious incidents • Methodology usually reflects that of Children SCRs/Domestic Homicide Reviews (DHR) • Composite action plan offers clear governance of implementation of necessary practice and system changes	• Perceived as overly bureaucratic • Structured process may mean it's not light-touch • Protracted-implementation of lessons learnt/recommendations may not be sufficiently responsive to time considerations • Can be costly - costs may not justify the outcomes • Can be perceived punitive, attributing blame which is not the focus of a SAR • Frontline staff often feel/are precluded, so disengagement from process and subsequent learning • Family involvement could be problematic unless thought through at the outset

NB Where other statutory reviews, such as a child SCRs or Domestic Homicide Reviews (DHR) overlap with an adult safeguarding review, consideration should be given to the most appropriate methodology to achieve joint outcomes and avoid duplications of process



OPTION B: Systems Analysis

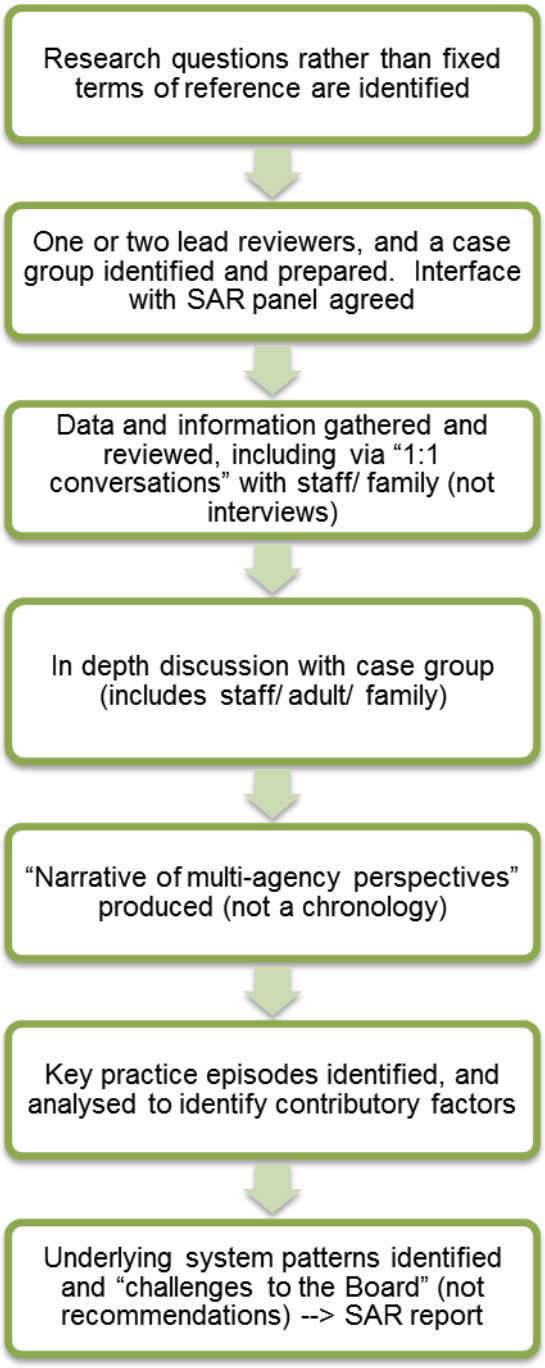
Key features:

- ✓ Team/ investigator led
- ✓ Staff/ adult/ family involved via interviews
- ✓ No single agency management reports
- ✓ Integrated chronology
- ✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
• Structured process of reflection • Reduced burden on individual agencies to produce management reports • Analysis from a team of reviewers may provide more balanced view • Managed approach to staff involvement may fit well where criminal proceedings are ongoing • Enables identification of multiple causes/ contributory factors and multiple causes • Range of pre-existing analysis tools available • Focusses on areas with greatest potential to cause future incidents • Based on thorough academic research and review • RCA tried and tested in healthcare and familiar to health sector SAB members.	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions • Staff/family involvement limited to contributing data, not to analysis • Potential for data inconsistency/ conflict, with no formal channel for clarification • Unfamiliar process to most SAB members • Trained reviewers not widely available • Structured process may mean it's not light-touch • RCA may be more suited to single events/incidents and not complex multi-agency issues

Available models:

Vincent et. al. (2003) Systems analysis of clinical incidents: the London Protocol
Woloshynowych et. al. (2005) Investigation and analysis of critical incidents NHS National Patient Safety Agency (NPSA) Root Cause Analysis



OPTION C: Learning Together

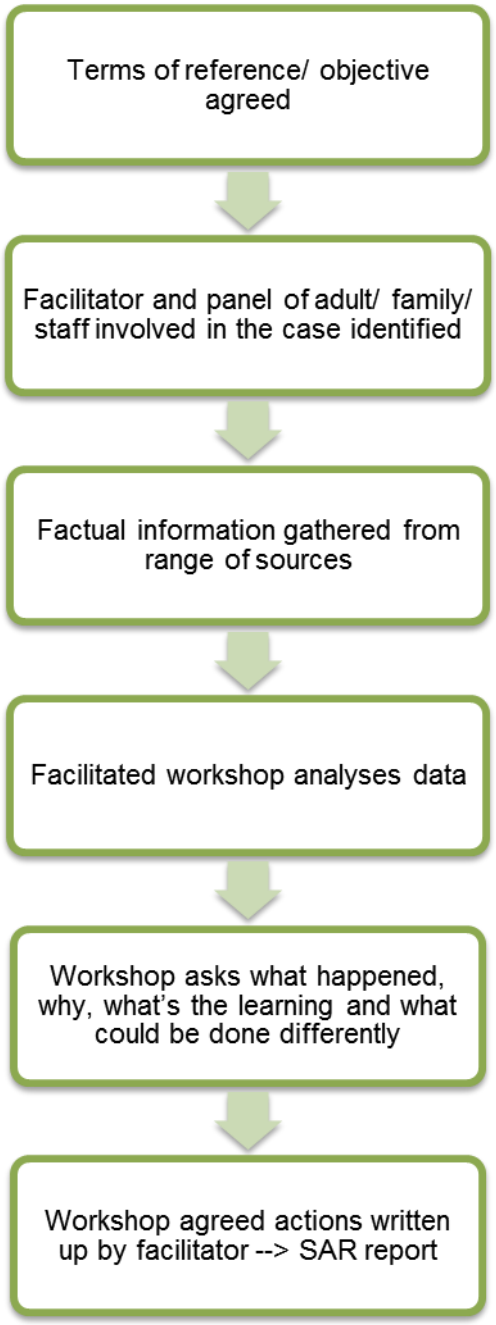
Key features:

- ✓ Lead reviewer led, with case group
- ✓ Staff/ adult/ family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; basic chronology
- ✓ Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages	Disadvantages
• Structured process of reflection • Reduced burden on individual agencies to produce management reports • Analysis from a team of reviewers and case group may provide more balanced view • Staff and volunteers participate fully in case group to provide information and test findings • Enables identification of multiple causes/ contributory factors and multiple causes • Tried and tested in children's safeguarding • Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity • Range of pre-existing analysis tools available	• Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/ actions • Challenge of managing the process with large numbers of professionals/ family involved • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses • Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR • Opportunity costs of professionals spending large amounts of time in meetings • Unfamiliar process to most SAB members • Structured process may mean it's not light-touch

Available models:

SCIE, Learning Together



OPTION D : Significant Incident Learning Process

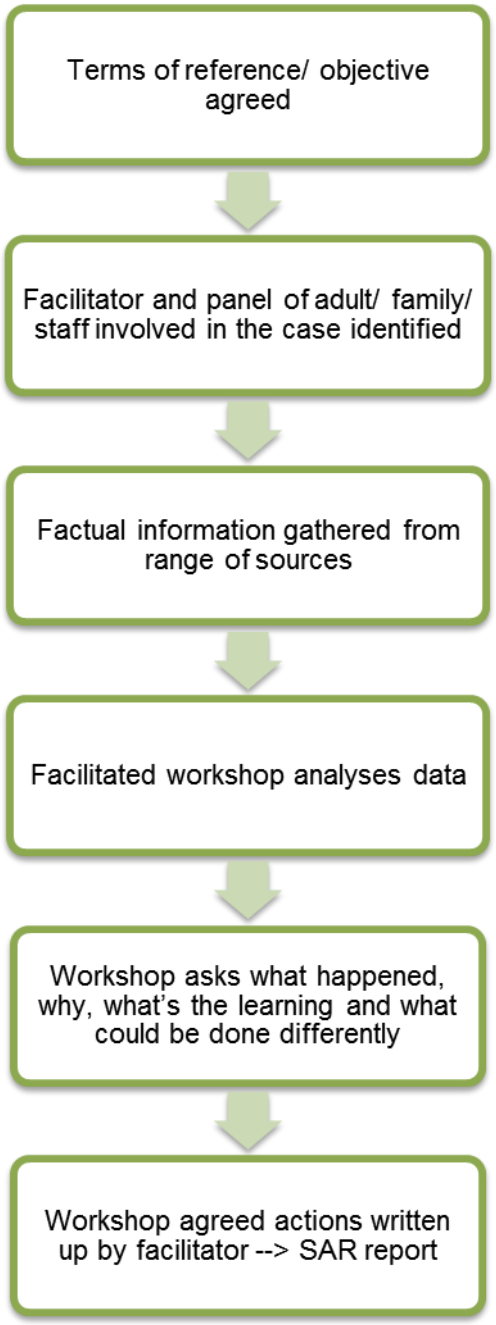
Key features:

- ✓ Review team and learning day led
- ✓ Staff/ family involved via learning days
- ✓ Single agency management reports
- ✓ Basic chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

Advantages	Disadvantages
• Flexible process of reflection – may offer more scope for taking a light-touch approach • Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants • Has similarities to traditional SCR approach, so more familiar to most SAB members • Agency management reports may better support single agency ownership of learning/actions • Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity	• Burden on individual agencies to produce management reports • Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR • Opportunity costs of professionals spending large amounts of time in learning days • Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses • Not been widely tried or tested, nor gone through thorough academic research/ review

Available models:

Tudor, Significant Incident Learning Process



OPTION E: Significant Event Analysis

Key features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/ adult/ family involved via panel
- ✓ Basic chronology
- ✓ No single agency management reports
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourage reflection and change.

Advantages	Disadvantages
• Light-touch and cost-effective approach • Yields learning quickly • Full contribution of learning from staff involved in the case • Shared ownership of learning • Reduced burden on individual agencies to produce management reports • May suit less complex or high-profile cases • Trained reviewers not required • Familiar to health colleagues	• Not designed to cope with complex cases • Lack of independent review team may undermine transparency/ legitimacy • Speed of review may reduce opportunities for consideration • Not designed to involve the family • Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses

Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis

Care Quality Commission, Significant Event Analysis

Royal College of General Practitioners, Significant Event Audit

OPTION F: Appreciative Enquiry

Key features:

- ✓ Panel led, with facilitator
- ✓ Staff involved via panel. Adult/ family involved via meeting
- ✓ Basic chronology
- ✓ Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

Advantages	Disadvantages
• Light-touch, cost-effective and yields learning quickly – process can be • completed in 2-3 days • Staff who worked on the case are fully involved • Shared ownership of learning • Effective model for good practice cases • Some trained facilitators available • Well-researched and reviewed academic model • Model understood fairly widely	• Not designed to cope with 'poor' practice/ systems 'failure' cases • Adult/ family only involved via a meeting • Speed of review may reduce opportunities for consideration • Model not well developed or tested in safeguarding. Minimal guidance available

Available models:

Julie Barnes, A new model for learning from serious case reviews

Newcastle Safeguarding Children's Board, Appreciative Inquiry Champions Group

9. INITIATING AND CONDUCTING A SAFEGUARDING ADULT REVIEW

9.1 As soon as practicable after it has been agreed **that a SAR should take place** the Independent Chair, in conjunction with relevant parties, including a Reviewer, the SAR or Panel Chair will:

- Draft the Terms of Reference for the SAR, including the period for which the SAR will focus
- Confirm which partner agencies should be part of the SAR Panel and which agencies will be involved.
- Consider how the adult at risk (where he or she has survived) will be supported and involved in the SAR process and agree who will contact them and how and by when
- Confirm how relatives, family or friends will be involved in the SAR and who will act as liaison and support to them and agree who will contact them and how and by when
- Confirm arrangements for any on-going support (e.g. legal support)
- Agree the methodology and timeline for completion of the SAR
- Agree the outline communication plan that will be necessary during the SAR process and at the conclusion of the SAR, ensuring that a communication strategy is in place, with clear leadership and co-ordination.
- Agree the final product that will be produced and how it will be presented to the SAB
- Propose how any learning from the SAR should be implemented
- Propose how the SAR should be published, taking account of factors that may emerge throughout the process
- Consider any other risk elements that may factor in the SAR and agree how the Independent Chair raises any issues that arise as part of the process and with who

9.3 The Independent Chair will:

9.3.1 Write to the Senior Manager of each relevant involved agency advising them that their agency's records relating to the adult at risk in question need to be secured with immediate effect. They will also be asked to nominate a representative for any SAR Panel that is subsequently convened.

9.3.2 Confirm any specific actions required of the agency in preparation for the SAR (depending on which methodology is being followed) and also timelines

10. INVOLVING THE PERSON, THEIR FAMILY AND/OR RELATIVES

10.1 Involving the adult at risk and/or their family are significant to the SAR process, whichever methodology is used. The purpose of a SAR and the process it follows will be unfamiliar for the 'adult at risk' and/or their family, adding to their distress and inevitable concerns. It will be a very sensitive time for everyone and consideration should be given at an early stage as to how this will be done; the ongoing identified support to those involved (how and who will provide it) with timely discussions taking place with the family or adult at risk, as to how the process will work, how they want to be involved and the type of outcomes that are likely from a SAR in general.

10.2 If the relative(s) to be involved requires support to be involved in the process they should be provided with an advocate in line with s68 Care Act. Consideration should be given at the outset as to how to effectively communicate with the adult at risk, their family/ representative and/or advocate. This will include informing them of the SAR and, if they are not SAR Panel members, sharing the outcomes in a way they wish.

10.3 Specific consideration should be given as to how to involve the 'adult at risk' so they are as involved in the process as far as they want to be, involving advocates as appropriate. If the 'adult at risk' has capacity to consent, and allows for family (or friends) to be involved in the SAR, they will be invited to contribute their views. This should be focused on purpose of a SAR. It is not about apportioning blame but is a review of agency functioning through which people are encouraged to reflect critically about their practice which translates into change and improved practice and working.

10.4 There should be clear consideration given at the outset as to any specific inputs that the family, relatives or the person who is the focus of the SAR should make or are encouraged to make (for example shaping the Terms of Reference or how the person who is subject of the SAR is referred to in any report).

10.5 Throughout the whole process due diligence, compassion and appropriate support must be provided and the Council's relevant community/locality team will provide this or an alternative should be arranged if that is more appropriate.

11. SUPPORTING STAFF AND OTHERS INVOLVED IN THE SAFEGUARDING ADULT REVIEW PROCESS

11.1 As soon as a SAR has been agreed, staff and others that have had involvement in the case should be notified of this decision by their agency, as well as the role they wish their staff to play in the review. The nature, scope and timescale of the SAR should be made clear at the earliest possible stage to staff, others and their line managers. It should be made clear that the review process is expected to be completed with six months.

11.2 Enabling and supporting staff who have been involved in a case that is subject of a SAR and to encourage they share their views on the case as appropriate, is a key to the agency reviewing their organisational involvement and collating the required information. It enables the best way possible to determine information about the situation and circumstances of the case in question, enables a much richer review of the agency's involvement and ensures staff feel involved and therefore more able to implement recommendations and actions that subsequently follow.

11.3 All agencies must support staff and practitioners involved in a SAR to "tell it like it is", without fear of retribution, so real learning and improvement can happen.

11.4 Agencies are responsible for ensuring their own staff, volunteers and others are provided with a safe environment to discuss their feelings and offered support where and as needed. The death or serious injury of an adult at risk will have an impact on staff and others and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

11.5 At the conclusion of the SAR each agency should consider the best way to involve staff and others in disseminating learning that has been identified, and to ensure oversight of practice that subsequently changes. It is also important to note that staff who may not have been directly involved in an issue that becomes a SAR may well have learning to consolidate from a SAR's outcome. This equally applies to the agency who may not also not have been directly involved but where disseminated learning is still required.

12. PROFESSIONAL CONDUCT ISSUES

12.1 This section must be read in conjunction with the London Multi-Agency Safeguarding Adults Policy and Procedures.

12.2 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR panel to deal with these.

12.3 Where concerns about an individual's practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel/ Sub group chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

13. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

13.1 The final report will include recommendations arising from a SAR. The complexity and proportionality of the report will be matched the issues in question. The report must include an easy to understand executive summary to enable the Adult at Risk or Family and Residents to understand the issues and the learning expected from the SAR

13.2 The SAR Panel Chair must ensure that there is sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR panel should form the basis of any SAR report, to be produced by the nominated author.

13.3 The SAR panel/ subgroup should receive and agree the draft report before it is presented to the SAB so that members are satisfied with the analysis and conclusions and these have been fully and fairly represented. If full agreement to the final report is an issue, then the SAB Independent Chair should be engaged to enable an appropriate way forward.

13.4 The Sub-group will be responsible for quality assuring the final SAR Report, and will use the SAR Quality Markers checklist as an aid to help them with this process. Final reports (including an Executive Summary, recommendations and any agency action plans) will be presented to the SAR Sub-Group ahead of any SAB meeting, to consider the issues and resulting recommendations seeking clarification on any issues as required. The final report, alongside recommendations for an Action Plan (developed by the SAR Sub Group) will then be presented to the SAB at the next full meeting.

13.5 Only when the BSAB agrees the report, it is accepted as final.

14. PUBLISHING REPORTS

14.1 The SAB recognises collective responsibility, open and transparent governance and the need for evolved learning. The BSAB's default position is to publish the report in full. However, sensitivity to the person and family may affect the decision. The SAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the SAB webpage, which at present is part of the Council's website. Agencies and SAB members can provide the relevant links as required.

14.2 The SAB Board Manager will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of seven years in line with prevailing Information Sharing Agreements, the Data Protection Act, Information Governance arrangement and other legal requirements. This can be reviewed if there is an overriding public interest or business need to do so.

14.3 The Care Act requires the SAB to publish the findings of any SAR in its annual report but doing so within the legal parameters of confidentiality. It at least should refer to a SAR being completed and how learning will be implemented. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report[3]

14.4 Any reports to be published must be fully anonymised. In doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised nomenclature. However if the Person subject to the review or their family would like to have them named then so long as they have understood the full implications of this decision, they may be named.

14.5 All SAR reports should be submitted to the SAR library within a suitable timeframe once published. The SAR Report should be appropriately coded to allow it to be effectively used within the library.

15. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

15.1 The real value of a SAR is to ensure that the relevant lessons, specific or wider learning, are understood, the impact considered, addressed and consolidated into improved working arrangements within and across all services supporting vulnerable adults at risk and that multi-agency

[3] Section 14.177-14.179 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

15.2 The SAR Sub-Group will be responsible for ensuring the development of a Composite Action Plan to ensure identified report recommendations are fully set out, prior to presentation to the SAB. Individual partner agencies are responsible for undertaking necessary actions to improve practice within their own organisations

15.3 Once a report and its recommendations have been confirmed by the SAB the Sub Group will retain oversight of implementation of the recommendations, with updates to the SAB as necessary. Agencies (either directly involved, or those who will benefit from the wider learning) will need to ensure actions are implemented updating the Sub Group on progress/achievement so the Composite Action Plan is effectively monitored.

15.4 The SAR subgroup will agree a summary learning brief that will be disseminated to staff

15.5 BSAB partners will be required to assure the SAR subgroup that learning from the SAR has been passed on to staff

15.6 In addition to SARs that are conducted by the BSAB, it will be as important to learn from SARs conducted by other SAB areas more generally.

16. SUPPORTING AND RESOURCING SAFEGUARDING ADULT REVIEWS

16.1 SARs can present a range of resource requirements, both in terms of immediate capacity and budget to appropriately service the process.

16.2 The SAB has to take a lead role in supporting the SAR process, supporting the setting up of the SAR Panel and supporting the SAR Sub Group in ensuring the right resources are made available to respond to this statutory requirement. This could include, but not limited to, budget to hire an independent chair or facilitator, additional capacity to facilitate all necessary actions, reports and writing of the report and support to relatives or people at the focus of the SAR in terms of advocacy or personal representatives.

16.3 Whilst recognising the challenges that all agencies are under in terms of resource constraints, this cannot impede the delivery of this statutory requirement.

17. MANAGEMENT OF CONFIDENTIAL DOCUMENTS AND INFORMATION SHARING

17.1 The Board should be aware of their responsibilities in relation to handling and retaining sensitive documents during the SAR process. All SAR subgroup and panel members should be made aware that the documents they are handling during the course of the SAR are highly sensitive and should not be disclosed to anyone unless there is an overriding business need to do so.

17.2 The SAB should ensure that all confidential documents be watermarked as confidential. Where documents have to be disseminated to subgroup or panel members, these should be sent out via secure email or using egress switch. Recipients should be reminded that documents are confidential, should be stored securely and not widely disclosed. Paper copies of confidential documents handed out at meetings should be returned to the Chair at the end of the meeting or should be disposed of via confidential waste.

17.3 Under s45 of the Care Act, organisations have a duty to disclose information requested by the Board for the purposes of a SAR. Any organisations that refuse to comply with information requests should be reminded of their duties under s45 of the Act.

17.4 Safeguarding Adults Boards should be mindful of the retention of sensitive data. Where a request has been made for a SAR and this has been rejected, information should be retained for one year following the referrer's notification that their case is not proceeding to a SAR. This will ensure that the Board has access to data should a request for a review of this decision be made or a complaint made to the LGO. After this period all information provided by the referrer should be destroyed. Where a case has proceeded to a SAR, information supplied by the referrer and partners should be kept securely for a period of seven years.

Barnet Safeguarding Adults Board

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

APPENDICES AND TOOLS

(Note: The following includes a selection of sample tools that can be used in helping a SAR Panel and are produced for simplicity and to enable clarity of relevant process)

APPENDIX A: REFERRAL FORM

BSAB Safeguarding Adults Review & Case Review Referral Form

Please complete as fully as possible

1. Referrer			
Name:		**Position:**	
Agency:		**Tel. number:**	
Address:		**Email:**	
Authorising Manager:		**Position:**	
Date of referral:			

Case Synopsis/Outline

Please provide as much information as possible

- details of referral agency
- Case outline
- status of adult, for example:
  - subject to an open safeguarding enquiry (or an enquiry closed within the previous 3 months)
  - subject of an Adult at Risk procedure
  - subject to DoLS at time of death/serious incident
  - experiencing domestic violence
  - other services person known to
  - person died after going missing from 24 hour setting
- Coroners Request?
- Fire-related death?
- brief summary of work undertaken/practice issues of concern
- Any other relevant factors

2. Adult At Risk details			
Last name/s:		**Date of birth:**	

Forename/s:		**Age** (if D.O.B. not known)**:**	
Other names used:		**Gender:**	
Home address:			
Ethnicity:			
Disability:			
Health and/or other presenting needs			
MOSAIC or RIO ID:			
Details of any other individuals or service providers involved			
Any other significant info: i.e. Next of Kin or Nearest Relative, Advocate, Relevant Persons Representative (R.P.R), etc			
Relevant documents (e.g. Risk Assessment, Safeguarding Referral etc) list here and provide			
Has any learning review already been undertaken			
Linked cases:			

3.	**Reason/s for requesting a discussion (<u>to be completed by the referring agency</u>):** Please state if you think adult with care and support needs (regardless of whether the local authority was meeting any of those needs) - Has died (including from suicide) and the BSAB knows or suspects that the death resulted from abuse or neglect (regardless of whether or not it knew or suspected the abuse or neglect before the person died); *OR* - Is still alive, and the BSAB knows or suspects that the adult has experienced serious abuse or neglect *OR* - Agencies or professionals in contact with the adult at risk or the person alleged to be causing neglect or harm did not recognise or respond appropriately to the abuse or neglect - Serious or apparently systematic abuse is taking or took place in an institutional setting - Multiple suspected abusers are involved Please ensure you state what is fact and what is opinion, being mindful of judgmental language.
Any other relevant information:	

What to do next:

Send the completed referral form to the BSAB Business Support Team either by secure email or post protect personal and/or sensitive information:

SafeguardingAdultsBoard@barnet.gov.uk

Barnet Safeguarding Adults Board
Barnet Council
2 Bristol Avenue
Colindale
NW9 4EW

APPENDIX B: DECLARATION OF INTEREST FORM

Name:	
Organisation:	
Has your organisation had any previous involvement in this case:	
Details of organisation involvement:	
Do you have any further information that you wish to be considered at the SAR meeting?	

Signature:	
Date:	

APPENDIX C: Initial Scoping and Information Sharing

Potential Safeguarding Adults Review

Barnet SAB has the lead responsibility for arranging and conducting a SAR and **must** do so when:

- An adult in its area dies 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.
- If the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. "*Serious abuse or neglect*" may include where:
    - the individual would have been likely to have died but for an intervention.
    - the individual suffered permanent harm as a result of abuse or neglect.
    - the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect;
    - the individual has sustained a potentially life threatening injury through abuse or neglect,

The SAB **may** also consider a SAR in other specific circumstances outside of the statutory requirement, including where, for example:

- A case featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

We have received notification of a serious incident and will, therefore, be holding a meeting to consider if this case meets the criteria. To inform the meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the adult. This initial scoping and information sharing form should, therefore, be returned to us **within 10 working days**.

Contact details of individual / agency completing this form

Name	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Addre telephone number and e-ma address

Date completed:

Background Information *(This should be completed before this form is sent out)*

Adult At Risk details			
Last name/s:		**Date of birth:**	
Forename/s:		**Age** (if D.O.B. not known)**:**	
Other names used:		**Gender:**	
Home address:			
Any other significant info: i.e. Next of Kin or Nearest Relative, Advocate, Relevant Persons Representative (R.P.R), etc			

Summary of Case:

Indicative time period to be looked at: *(Good practice suggests that the time period examined should be limited. However, please include information from outside this time period if you feel it is relevant to the case.)*

Section 1: Agency Information and Involvement

1.	**Provide a brief summary of your agency's involvement with the adult.** *(Please focus on the key significant events in chronological order and, where appropriate, include the date of commencement and completion of service.)*
2.	**Brief analysis of individual or / and agency practice.** *(Please identify any outstanding practice or potential learning).*
3.	**Please identify any areas for concern as to the way in which partners have worked together to safeguard the adult.**
4.	**Are you aware of the involvement of any other agencies? If yes, please give details.**
5.	**Please include any further relevant information that you wish to bring to the attention of the SAR sub group meeting.**

What to do next:

Send the completed referral form to the BSAB Business Support Team either by secure email or post protect personal and/or sensitive information:

SafeguardingAdultsBoard@barnet.gov.uk

Barnet Safeguarding Adults Board
Barnet Council
2 Bristol Avenue
Colindale

NW9 4EW

A multi-agency review will be undertaken and you will be informed of the outcome.

APPENDIX D: RECOMENDATION FORM FOR SAR REFERRALS

Case	
Date reviewed	

D**ECISION**

Does the person(s) have diagnosed or undiagnosed care and support needs?	
Comments	
Has the person(s) died or suffered serious harm?	
Comments	
Has the person(s) died or suffered serious harm as a result of abuse or neglect?	
Comments	

Is there reasonable cause for concern about how BSAB partners have worked together to effectively care for the person(s) involved	
Comments	
Are there any clearly identified areas of learning and practice improvement that could significantly improve the way that adults are safeguarded	
Comments	
Are there any other factors that may have influenced the SAR sub-group decision making	
Comments	

NEXT STEPS

What course of action, if any, has been agreed by the SAR sub-group?

(Optional) Who will be responsible for leading this?