London Safeguarding Adult Review (SAR) Principles and Checklist – a guidance

1. Aim

1.1 London ADASS and the London Safeguarding Professionals Steering Group have developed this set of principles and checklist to support partners across London to standardise the process of effectively conducting a SAR. It has been designed to ensure that despite each SAR case being unique, the London Boroughs and Local Safeguarding Adult Board (SAB) discharge its statutory duty using best practice. This document intends to support multi-agency professionals in requesting and completing a SAR.

1.2 This guidance will be used in conjunction with the London multi-agency safeguarding adults policy and procedures and has been designed with the aim standardising how SARs are conducted, as a result of the findings from the SAR report by Michael Preston-Shoot and Suzy Braye.

1.3 The aim of the checklist is to provide a reference point for Local Authorities who have a SAR protocol in place and a checklist for those that do not.

The Checklist below will outline recommended actions which need to be completed.

A)	**Criteria for a Safeguarding Adult Review**
B)	**Requesting a SAR to be undertaken** **B.1) Process if the request has not met the criteria for commissioning a SAR** **B.2) Learning event**
C)	**Making decisions on the SAR Methodology**
D)	**Methodology options**
E)	**Adult and family involvement**
F)	**Supporting staff and others in involved**
G)	**Professional conduct**
H)	**SAR reports and recommendations**
I)	**Quality assurance of the SAR**
J)	**Acting on the recommendations of the SAR**

2. Introduction

2.1 Section 44 of The Care Act 2014[1] requires that the Safeguarding Adult Board (SAB) is 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 framework.

2.2 Each Local Authority SAB must arrange a SAR when an adult in the 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

[1] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuseor-neglect/enacted

[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

circumstances apply where an adult is still alive but has experienced serious neglect or abuse. See section A) 'Criteria for a Safeguarding Adult Review' within the checklist defines "Serious abuse or neglect".

2.3 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.

2.4 It should be noted that the SAR process is usually reserved for the most serious cases, involving a number of agencies. However, there may be circumstances where a case does not meet the threshold of a SAR but the Board, or its SAR group, considers there could be some learning for the local system. It is suggested that a learning review is undertaken. This does not need to be independent and might involve sharing the root cause analysis report from a health provider in respect of a serious patient safety incident. The learning review might take the form of a practitioner event to allow for learning to be shared regarding best practice and developing new ways of working. If there is clear evidence that learning has been shared within the organisation (Serious incidents, 72 hour review) due consideration may be taken to not proceed to a learning event, in view of resource, capacity and duplication. (See section B.1 'Learning event' within the checklist provides information about how to hold these learning events)

2.5 The individual involved does not have to have been in receipt of care and support services for the SAB to arrange a review in relation to them. The family, or the individual if alive, and if they are able and chose to, should be fully involved throughout the process. (See section E) 'Adult and family involvement' below).

3. Safeguarding adult review governance

3.1 The Safeguarding Adult Board of the London Borough has the lead responsibility for carrying out a Safeguarding Adult Review (SAR) based upon receipt of a referral, and for considering its findings and recommendations.

3.2 In cases other review processes could be initiated (e.g. Domestic Homicide Review, Child Serious Case Review etc.) a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair. A final joint report would need to be produced. The local strategic partnerships should have agreements in place to share the decision making regarding the most appropriate route for a review, taking note of the relevant legislation underpinning the respective reviews.

4. Purpose of a safeguarding adult review

4.1 The purpose of conducting 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 and establish whether there are lessons to be learnt from the circumstances of the case.

• Review the effectiveness of procedures and their application of both multiagency and those of individual organisations. This can be used to inform and improve local inter-agency practice by acting on learning in order to reduce the likelihood of similar harm occurring again.

• Prepare or commission an Overview Report that analyses and makes recommendations that will contribute to improving safeguarding outcomes for adults at risk of abuse or neglect, on the basis of information and evidence provided to a SAR Panel.

4.1 The SAR is not:

- An enquiry into how an adult at risk died or to allocate blame. It is to learn from such situations, and apply these lessons to future cases to prevent similar harm occurring again.
- To hold any individual or organisation to account. There are other processes and legislations that exist for such accountability for example; criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulatory bodies.]

Principles

When undertaking a SAR the 6 Six Safeguarding Principles for Adult Safeguarding should be taken into consideration:

Empowerment
People being supported and encouraged to make their own 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
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability
Accountability and transparency in safeguarding practice.

In addition, it is recommended that the following 5 principles are also considered as a basis for good practice, as outlined by the Social Care Institute for Excellence:

5 Principles for conducting a Safeguarding Adult Review

1. Share Learning

The aim of a SAR is not to place blame, but to share learning that will improve the way agencies work individually and together

2. Process
Each case and SAR should be treated as unique. The process should include the recommended elements however, it should be proportional to the severity of the case and it should utilise the appropriate methodology that will maximise the learning.

3. Open and honest
Throughout the SAR Process all parties should communicate and voice their opinions and their views openly and honestly with an appropriate "tell it like it is" approach.

4. Understanding and sensitive
The conditions of each case will need to be approached with understanding of the different perspective as action may have been taken in good faith. The circumstances of the case will require a level of sensitivity especially when the individual and/or their relatives are involved.

5. Encourage excellence
The act of sharing the learning within and across agencies involved is to promote and encourage excellence within safeguarding.
The checklist below outline key aspects and best practice when conducting a SAR

Section A

Criteria for a Safeguarding Adult Review

The Safeguarding Adult Board (SAB) has the lead responsibility for arranging and conducting a SAR and must do so when:

- An adult in a London Borough dies as a result of abuse or neglect AND
- There is concern that partner agencies could have worked more effectively to protect the adult OR
- Where an adult is still alive but has experienced serious abuse or neglect

Note: "Serious abuse or neglect" may include where:

- *It is likely that an individual would have died if not for an intervention.*
- *The individual suffered permanent harm as a result of abuse or neglect.*
- *Reduced capacity or quality of life (whether because of physical or psychological effects) led to the abuse or neglect.*

Select from the options below		Selection
I.	An adult in a London Borough died as a result of abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult	
II.	The adult is still alive but has experienced serious abuse or neglect	
III.	There are concerns and issues are reoccurring and the SAB are looking to proactively review these in order tackle practice areas or issues before serious abuse or neglect arises. (Non Statutory)	
IV.	There is learning from good practice in interagency working can be identified and applied to improve practice and outcomes for adults. (Non Statutory)	

Section B	
Requesting a SAR to be undertaken	**Tick when complete**
The requestor has reasonable grounds to believe that a SAR has been met	
The local SAR request form has been competed	
The SAR has been logged	

The relevant statutory director(s) have been notified	
The SAB Chair has convened a panel of approx. three Board members not involved with the case to consider the SAR request	
Enough information has been submitted to make a decision as to whether the SAR criteria has been met *Note: if the board members have decided that there request does not meet the criteria for a SAR please go to section B.1*	
The statutory Director has been notified	
The requestor has been notified	
The Panel and SAB Chair have agreed the most appropriate/beneficial methodology to be employed	
The SAR has been commissioned	
Section B.1	
Process if the request has not met the criteria for commissioning a SAR	**Tick when complete**
The SAB have considered whether an alternative review/ learning event/ audit are in place	
The SAB Chair has been notified of the decision	
The referrer has been notified by letter from the Chair of the Sub-Group or the Board, within a reasonable time scale, outlining the reasons for the decision *Note: the requestor has the right to appeal the decision, if the appeal is upheld the SAR process will continue to from this point onwards however, if the SAR criteria has not been met and the requestor's appeal has not been upheld, the SAR log should be updated and the request should be closed. Refer to section B.2 below on the process to holding a learning event.*	
Section B2	
Learning event A learning event can be organised when the decision has been made that the criteria does not meet the SAR threshold. Learning events are a way of having open and honest conversations using an action focussed approach. The approach will vary with each case. However, their benefit and value is not to be underestimated. Learning events can encourage excellence within an organisation and improve the way organisations and agencies work together.	**Tick when complete**
The agencies involved have been contacted and are willing to partake in a learning event	
A facilitator has been appointed	
The group have met and the discussions have led to an action plan with dates for completion	
The responsible person has ensured that the actions agreed have been completed in a timely manner and has logged the outcomes	

Section C	
Making decisions on the SAR Methodology The circumstance of the case will dictate the most appropriate methodology. Despite the methodology employed the following elements should feature in the SAR. The range and type of learning will be impacted by the type of methodology used.	**Tick when complete**
The Panel and Chair have appointed a SAR Chair, who is independent of the case under review and of the organisations involved. They have the appropriate skills, knowledge and experience. They will be able to: • motivate others	

• handle multiple competing perspectives with strong leadership skills • analyse qualitative data • use their Adult safeguarding knowledge and experience to implement a collaborative approach to problem solving • This person could be drawn from a list of multiagency professionals in a senior role to promote transparency and independence.	
A SAR Panel of relevant people responsible for scrutinising information submitted has been appointed. They will be responsible for appointing a reviewer with the relevant skills, experience and references. *Note: The size of the panel should be proportionate to the nature and complexity of the review*	
The Terms of Reference have been developed outlining roles, responsibilities, scope and focus. This does not include issues that are being resolved using other legislation.	
Discussions have been had with the family / individual involved as to the level of engagement and their expectations (See section E for more details)	
Professionals and organisations involved with the individual have been notified that they have the opportunity to contribute (See section F more details)	
The methodology includes a final report which set out recommendations and wider learning (See section H more details)	

Section D	
Methodology options SAR methodologies listed below are taken from the SCIE *Serious Safeguarding Adults Reviews: Guidance note on options for London* however; this is not an exhaustive list. The methodology to be adopted should be aligned with the complexity of the case. See the link above for more information on the advantages and disadvantages of each option. The Panel should research other approaches being utilised by other boroughs.	**Tick when complete**
Option One – Traditional SCR approach	
Option Two – Action learning approach	
Option Three – Peer review approach	
All members of the SAB are aware of the methodology chose and agree its suitability	

Section E	
Adult and family involvement	**Tick when complete**
Support and advocacy has been considered and organised for the individual involved if they are to engage with the review	
Support and advocacy has been considered and organised for the relatives of the individual involved if they are to engage with the review	
Arrangements have been confirmed for any on-going support (e.g. legal support)	
The individual and their families have been made aware that the SAR is not to apportion blame but to use the learning to improve practice and working within and between the agencies involved	
There has been clear consideration given to the specific input of the individual and their family if they have survived	
Due diligence, compassion and appropriate support has been provided to the individual involved and /or their relatives	

Section F	
Supporting staff and others in involved	**Tick when complete**
The staff and agencies have been notified that they have been involved in a case that will be reviewed and they have considered how they would like to/ would like their staff to engage with the SAR	
The nature, scope and time scales have been communicated to the staff involved and their managers	
Staff have been encouraged to share their opinions and views in an open and honest way, as this will facilitate beneficial learning	
Agencies are aware that they have a responsibility to providing a safe environment for their staff to discuss their feeling and receive support	
Agencies have decided how they will share the learnings once the conclusions have been published	
Agencies have made it clear to their staff that they may need to engage in learning despite not being involved in the SAR themselves	

Section G	
Professional conduct	**Tick when complete**
The London Multi-Agency Safeguarding Adults Policy and Procedures has been reviewed in conjunction with this section (especially pages 35-37)	
It has been made clear to staff and all agencies that the SAR Panel are not to deal with issues of professional conduct that may become apparent during a SAR	
The SAR Panel Chair has fed back the individual conduct issues to the relevant agency as it is their responsibility to trigger any action in proportion with the concerns passed on by the SAR Panel	

Section H	
SAR reports and recommendations	**Tick when complete**
The London Multi-Agency Safeguarding Adults Policy and Procedures has been reviewed in conjunction with this section	
The SAR panel chair has facilitated sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR panel throughout the SAR process.	
The SAR report has been based upon the systematic, practice and procedural issues and the key learnings have been identified	
The SAR panel have reviewed the report and are in agreement with the conclusions and recommendations proposed before it is presented to the SAB	
The individual involved and / or their relatives have been offered the opportunity to review the report	
The SAB have made a decision as to who the report will be made available to and to what extent i.e. full / part of the report. They have considered the reputational risk and national learning	
The report has been anonymised	
The report has been stored according to legal requirement, the Data Protection Act and the local authorities information sharing agreement	

Section I	
Quality assurance of the SAR Quality assurances are embedded throughout the SAR process from appointing an Independent Chair to lead the review, to the giving the individual involved/ their families an opportunity to review the report. The first element of quality assurance is to demonstrate clear evidence that the SAR learning report has been embedded. There are other arrangements that could be put in place which will allow for further assurance. You could ensure you have:	**Tick when complete**
Employed the most appropriate SAR methodology for the individual case	
Commissioned a suitably skilled, experienced and independent SAR reviewer to lead the review and analysis. They have the appropriate skills and training/shadowing experience	
Chosen independent SAR panel members with no conflict of interest	
Focussed on outlining the causal factors and systems learning	
Requirements have been written into the terms of reference for the SAR to take a broad learning approach	
The report provides a sound analysis of what happened, why and what action needs to be taken to prevent the same issues occurring again	
The report has enough information for the SAB to review and quality assure	
The report provides practical value to the individuals and organisations involved	

Section J	
Acting on the recommendations of the SAR	**Tick when complete**
SAB have translated the recommendations from the report to into a multi-agency action plan *Note: The SAR will need to be published within the local Authority's Annual Report even if they choose not to implement these actions.*	
The action plan includes: • The actions that are needed. • Who is responsible for specific actions • Timescales for completion of actions are appropriate with specific end dates • The intended outcomes: what will change as a result • Mechanisms for monitoring and reviewing intended improvements. • The plan for dissemination of the SAR report or its key findings.	
The individual agencies have produced their own action plan where necessary as per internal governance processes	
The Board are aware that they are responsible for ensuring that the actions have been implemented from the multiagency action plan	

End