# Safeguarding Adults Reviews (SARs)

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The Care Act 2014 introduced statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews), and mandated when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

## 1. Criteria

Criteria from s44 of the Care Act 2014:

(1) An Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult\* has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) The adult\* is still alive, and

(b) The SAB knows or suspects that the adult has experienced serious\*\* abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

\* the adult must be in the SABs area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

\*\* something can be considered serious abuse or neglect where, for example 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 (whether because of physical or psychological effects) as a result of the abuse or neglect.

## 2. Purpose

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently, so that they could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The purpose of the reviews 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 CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs, their response will be defensive and their participation guarded and partial.

## 3. Principles

The following principles apply to all reviews:

• there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

• the approach taken to reviews should be proportionate according to

the scale and level of complexity of the issues being examined;

• the individual (where able) and their 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;

• the Safeguarding Partnership is responsible for the review and must assure themselves

that it takes place in a timely manner and appropriate action is taken

to secure improvement in practices;

• 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 and

• professionals/practitioners should be involved fully in reviews and

invited to contribute their perspectives.

• the judgement should make meaningful reference to the principles of Making Safeguarding Personal and the six core safeguarding.

## 4. Referral Process to the Practice Review Group

The Walsall SAR referral form ([Appendix 1](#Appendix1)) must be completed and submitted to Walsall Safeguarding Partnership Business Unit subgroup before a case can be considered for review within the SAR process. The completed form explains why the referrer considers that the case meets the threshold for a SAR. All referral forms must have been approved by the referrers’ line manager before submission to SAR subgroup for consideration.

The referral form needs to be securely returned to the Walsall Safeguarding Partnership the following email account [safeguardingbusinessunit@walsall.gov.uk](mailto:safeguardingbusinessunit@walsall.gov.uk)

If the referrer does not have access to a secure email account to send the form, they should contact the Walsall Safeguarding Business Unit on 01922 650320 to agree an alternative secure submission. An email acknowledgement of the referral will be returned within two working days.

## 5. Decision regarding whether the SAR criteria is met

The Business Unit should acknowledge receipt of a SAR referral at the earliest opportunity by return of email to the referrer.

They will also convene a virtual meeting of the Statutory Safeguarding Partners (Police, Social Care and Health) of PRG with the referrer to agree whether or not the set criteria for a SAR is met and the timeframe to be scoped. If a decision is made that the Criteria for a SAR is met then the Business Unit will send out the Scoping Documents ([Appendix B](#Appendix2)) to all agencies known to have been involved. The request will include a time frame for completion of the review. It is expected that scoping documents will be returned within 15 working days.

The Safeguarding Partnership Business Unit is responsible for notifying the referrer of the decision made. Should the referrer disagree with the decision then this should be referred for further discussion with the Chair of the PRG.

The Safeguarding Partnership Business Unit and the Chair of PRG will also agree a plan for notifying the subject/ family member of the intention to complete a review and to agree how they will be involved. The family should be invited to share any information that they believe is important and to request any additional learning is looked into.6. Convening a SAR Meeting with Rapid Review **Methodology**

Once returned the Business Unit will complete a collated SAR Rapid Review scoping document (Chronology) and convene a EO/PRG Meeting.

The purpose of the PRG Meeting is to:

* Consider the Rapid Review scoping information
* Consider any gaps in the scoping information
* Identify whether there is immediate learning and actions that are required.
* Summarise the learning
* Document and plan how this learning and any recommendations will be progressed across agencies
* Agree how learning and recommendations will be shared with the wider Safeguarding Partnership
* Consider whether the risks identified warrant further additional review with alternative methodology is required and if that is required recommend how this should be carried out

## 7. SAR in Rapid Time/ Rapid Review SAR

Should the PRG agree that the scoping completed has identified all relevant learning and that arrangements have been made to take forward that learning effectively they can conclude that no additional action is required.

The findings will be recorded and shared with PRG members and the referrer. The findings will be logged by the Business Unit as learning identified from the SAR progress so that recommendations can be tracked until all actions are completed. This process is overseen by PRG.

The learning will also be shared with the Practice Development Group who will incorporate into relevant training and communications.

The SAR can be concluded when all of the above steps have been taken.

**Family and Subject Adult Involvement**

Where the learning has been identified by the SAR in rapid time process the Business Manager and the Chair of PRG must inform the family and where appropriate the Subject Adult of the findings and proposed actions.

Where further review deemed necessary the family should be informed of this intention.

Where a traditional SAR is to be completed the responsibility for informing the family and adult and involving them in the process will rest with the Business Manager and Independent Author.

## 8. SAR not concluded following the Rapid Review process

Should the PRG conclude that there is additional work required to:

1. understand the factors contributing to the event(s) necessitating a SAR
2. understand the learning and changes to practice required as a result of the event(s)

They need to decide on the most appropriate methodology to complete the SAR.

Methodologies to consider are listed below:

1. **SAR using traditional Methodology**

This model is traditionally used where there are demonstrably serious concerns about the effectiveness of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice. This model includes:

* the appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process
* appointment of an Independent Report Author to write the overview report and summary report
* involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning chronologies of events
* formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships publishing the report in full.

**The benefits of this model are:**

* it is likely to be familiar to partners
* possible greater confidence politically and publicly as it is seen as a
* tried and tested methodology.
* robust process for multiple, or high profile/serious incidents.

**The drawbacks of this model are:**

* methodology stems from children’s arena so process to adults is not
* so familiar
* resource intensive
* Time consuming and can delay identification and implementation of learning
* costly
* can sometimes be perceived as punitive and
* does not always facilitate frontline practitioner input

1. **Action Learning Approach**

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity. There are a number of agencies and individuals who have developed specific versions of action learning models, including:

• Social Care Institute for Excellence (SCIE)-Learning Together Model

• Health and Social Care Advisory Service (HASCAS)

• Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles. The broad methodology is:

• Scoping of review/terms of reference: identification of key

agencies/personnel, roles; timeframes :( completion, span of person’s

history); specific areas of focus/exploration

• Appointment of facilitator and overview report author

• Production/review of relevant evidence, the prevailing procedural

guidance, via chronology, summary of events and key issues from

designated agencies

• Material circulated to attendees of learning event; anticipated

attendees to include members from SAB; frontline staff/line managers;

agency report authors; other co-opted experts (where identified);

facilitator and/or overview report author

• Learning event(s) to consider what happened and why, areas of good

practice, areas for improvement and lessons learnt

• Consolidation into an overview report, with analysis of key issues,

lessons and recommendations

• Event to consider first draft of the overview report and action plan

• Final overview report presented to Safeguarding Adults Board, agree

dissemination of learning, monitoring of implementation

• Follow up event to consider action plan recommendations

• Ongoing monitoring via the Safeguarding Adults Board

**The benefits of this model are:**

• Conclusions can be realised quicker and embedded in learning

• cost effective

• Enhances partnership working and collaborative problem solving

• Encompasses frontline staff involvement

• Learning takes place through the process enhancing learning.

**The drawbacks of this model are:**

• Methodology less familiar to many

• Events require effective facilitation

• Specific versions such as SCIE Learning Together and SILP are

copyrighted

1. **Individual Agency Review**

This model would be relevant when a serious incident or near miss identifies just one agency being involved or one agency who may need to learn from the situation and there are no implications or concerns regarding involvement of other agencies. Such reviews undertaken under the SAR process should always be instigated and scrutinised by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking an Individual Agency Review with a safeguarding element, in order for the Board to consider any transferable learning across partnerships. Where instigated by the SAB, any recommendations should be considered by the SAB.

**Circumstances when this model might be appropriate:**

• Serious Incidents

• Implications relate to an individual agency, but lessons could be

shared, applied and learnt across the partnership

• Where serious harm and/or abuse was likely to occur, but had been

prevented by good practice (positive learning)

**The benefits of this model are:**

• Provides an opportunity for learning from an individual agency

• Enables individual agency scrutiny into a specific area

• Assists in implementing ‘Duty of Candour’

• Cost effective and proportionate

**The drawbacks of this model are:**

• Can be seen as outside the SAR purpose of multi-agency learning

• Rely on individual agency to scrutinise the incident without a multiagency perspective

It is accepted that this is already part of the national Serious Incident Reporting Framework (SIRI) in health settings. Where necessary final reports of SIRI’s will be reviewed by the board.

1. **The Peer Review Approach**

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector lead improvement programs which is an approach being increasingly used within Adult Social Care. Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

• Peers can be identified from SAB Board members or

• Peers could be sourced from another area/SAB which could be developed as part of regional, reciprocal arrangements

**The benefits of this model are:**

• Increased learning and ownership if peers are from the SAB

• Objective, independent perspective

• Can be part of reciprocal arrangements across/between partnerships

• Cost effective and proportionate

**The drawbacks of this model are:**

• Capacity issues within partner agencies may restrict availability and

responsiveness

• Skill and experience issues if SARs are infrequent

• Potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases

1. **Significant event analysis/audit (SEA)**

SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it. NHS England has published a Serious Incident Framework in March 2015

**The benefits of this model are:**

• It is not a new technique – doctors have long discussed cases for

educational and professional purposes.

• Cost effective and proportionate

**The drawbacks of this model are:**

• Seen as a model that relates only to Health.

1. **Case file audit (multi or single agency, tabletop or interactive)**

Case file audit can be a powerful driver in improving the quality of front-line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken.

**Case file audits can be single agency or multi agency.**

They can be undertaken in a number of ways:

• As a table-top exercise (therefore no input from practitioners)

• Interactive with partners and or practitioners.

• Interactive with the adult and or their family.

• Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

• Flexible – in that they can be conducted in many different ways.

• Quicker learning can be achieved.

• Cost effective and proportionate

**The drawbacks of this model are:**

• There may be limits to learning from sole examination of paper records.

• Due to the timescales it can be more difficult to engage the family as they may have suffered loss/ trauma very recently.

1. **Root Cause Analysis (RCA)**

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors, the root causes of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

**General principles of Root Cause Analysis:**

• RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes

• To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence

• There is usually more than one potential root cause of a problem • To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause (s) and the incident, not just the obvious.

**The benefits of this model are:**

• The methodology is well known and frequently used in the NHS

• Focus is on the root cause and not on apportioning blame or fault

• Effective for single agency issues especially those related to NHS services.

**The drawbacks of this model are:**

• Requires skills and knowledge of RCA tools;

• Resource intensive

1. **Learning events**

Agencies may be invited to event for the purpose of supporting the safeguarding system to learn. Learning events can be useful at 3 stages:

• As part of the SAR methodology

• After a SAR to share findings

• After a SAR to evaluate the impact of implementing the recommendations.

## 9) Duty of Candour

All members of a Safeguarding Partnership are required to have a culture of openness, transparency and candour within their day to day work and with the SAB. In interpreting this “duty of candour”, we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

**- Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

**- Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

**- Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

In practice, as members of the Safeguarding Partnership, all agencies have a responsibility to ensure they are open and transparent with the SAB when incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incidents that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying both their own learning and multi-agency learning.

## 10. Roles and responsibilities of the Safeguarding Partnership (Adults)

Under the Care Act 2014, Safeguarding Adults Boards (SABs) are responsible for:

• Arranging Safeguarding Adults Reviews (SARs)

• Ensuring the SAR is completed in a reasonable time

• Ensuring there is appropriate involvement in the review process of

professionals and organisations who were involved with the adult.

• Ensuring the adult or their family is not only communicated with but

involved in the review where possible

• Receiving the recommendations

• Agreeing an action plan

• Ensuring the recommendations and action plan are implemented

• Publishing information about SARs in the Annual Report including what recommendations have and have not been accepted

**i) Independent Chair of Walsall Safeguarding Partnership (incorporating the Safeguarding Adult Board function)**

The Independent Chair of Walsall Safeguarding Partnership, discharging the duty for the Safeguarding Adult Board, is responsible for the decision to undertake a SAR in response to the Practice Review Group (PRG) recommendations but will discuss this with the Joint Executive of the Safeguarding Partnership.

The Independent chair is responsible for providing regular updates on the progress of any SARs to the Joint Executive of the Safeguarding Partnership.

**ii) Safeguarding Adult Partnership members**

It is the responsibility of the Safeguarding Partnership (Adults) members to nominate experienced, senior staff from their organisation to participate in SARs. These staff should be supported by their agency’s senior manager responsible for the delivery of this agenda within the respective organisation. They should not have been directly involved in the case under review.

Due to the time consuming and complex nature of this process all the members are responsible for discussing progress with their nominated learning report author. They are also expected to provide these staff with the support and guidance they may require to construct a report which meets the Safeguarding Partnership’s quality standards, recognising that providing them with the protected time to complete the review should be a prerequisite of their nomination.

The members of Safeguarding Partnership (Adults) are responsible for the monitoring and the

implementation of their organisation’s actions within the multi-agency plan.

Members will be expected to provide PRG with the evidence that their actions have been delivered to plan.

**iii) Practice Review Group (PRG)**

The Practice Review Group is responsible for making the recommendation to the Executive Leads for the Safeguarding Partnership (Adults) when they consider a case meets the criteria for a SAR, this recommendation can only be made by the PRG. The final decision to undertake a SAR is made by the Independent Chair and the Joint Executive Leads for the Safeguarding Partnership.

Where the case is agreed as meeting the criteria for a SAR, the SAR subgroup will make recommendations relating to preferred overall approach applied to the SAR, or delegate this solely to the Review Panel.

The approach to be taken to ensure engagement with the adult at risk, family members and person(s) or organisations is agreed by the SAR Subgroup and their recommended approach is presented to the Executive Leads for the Statutory Safeguarding Partners to approve.

The PRG is responsible for the on-going performance management of the SAR process and for providing progress updates as a standing agenda item to each Operations and Scrutiny meeting and through to the Statutory Safeguarding Partners.

**iv) The Safeguarding Partnership Business Unit**

The Business Unit team is responsible for providing the operational and administration support function to both PRG, Operations and Scrutiny and the Executive Statutory Partners.

**Joint Safeguarding Business Manager** – is responsible for all aspects of the business management relating to CSAB. The Boards Business manager will take responsibility for the coordination of all aspects of the SAR process, including the management of the timeline for key meetings, report submissions and progress updates to CSAB and SAR subgroup and also provides the central point of contact for the SAR Independent author and chair, agency report authors, panel members.

**Boards Business Manager Administration Support Officers** – provide the overarching administration support to the SAR process, working closely with the Boards Business Manager

**- v)** **Independent1 Chair for the SAR**

The Independent Chair is commissioned by the SAR subgroup. They will be appointed in relation to their knowledge, experience and skill to undertake this complex and challenging role as set out in the contract agreement.

The Chair is accountable to the PRG chair providing regular progress updates. The chair will also be expected to achieve a consensus with the panel members in respect of the key areas for earning and improvement.

In line with Safeguarding Partnership aspiration, the SAR chair will provide all of those involved in the process with an opportunity to positively reflect on events and to learn and develop as a result of the review. The process should be managed without prejudice, focusing primarily on the positive but recognising that had events been managed differently, the outcome may have been different. All the partner agencies involved must also be kept up to date by the SAR Chair with the progress and any relevant learning that has been achieved in the process of the review. The SAR Chair in conjunction with the independent author is responsible for presenting the final overview report to the Safeguarding Partnership for consideration and endorsement by the Statutory Executive Leads.

**vi) SAR Independent Author**

An Independent SAR author will be commissioned by the PRG. The role of the independent author is to work in collaboration with all the partner agencies involved in the SAR to ensure that all of the issues raised within the terms of reference have been critically analysed and addressed through the review process. The independent author is responsible for producing an overview report which includes the recommendations which have been agreed with the SAR Panel members. The recommendations must deliver positive learning to support improvements in practice and services across Walsall.

The independent author in conjunction with the SAR Chair is responsible for presenting the final overview report to the PRG and joint Executive partners from the Safeguarding Partnership for consideration and endorsement.

**vii) Safeguarding Review Panel members**

SAR panel members are in most instances nominated by their agency’s PRG representative, but this can also be the subgroup member. The panel member must be a senior manager who has no line management responsibility or previous connection with the case. The panel member must be sufficiently senior and experienced to be able to effect sustainable change in their organisation and be able to work with the other panel members to influence change and improvement across the wider partnership.

The individual agency panel member should provide support and guidance to their nominated learning report author, these two roles provide separate functions within the SAR process, therefore, the SAR subgroup recommends that the participating agency should nominate two individuals.

Where the panel has been delegated by the PRG up they will recommend which methodology and provide details of the approach including terms of reference and the time frame.

The SAR panel members are all individually responsible for providing accurate and timely feedback to their organisation SAB member relating to the SAR progress or issues which may need immediate intervention at a senior level.

1. **Internal Management Review Report Authors/ senior management oversight and sign off**

The internal management review author is nominated by their organisation to produce a learning focused report. They will have had no previous involvement or connection with case, but they will have had some experience at writing objective reports. They need to have knowledge of professional standards and be familiar with current research in relation to evidence based practice.

The learning report author will have access to mentorship and support throughout the process. While LRA is responsible for their report the accountability for authorising, the report sits with senior manager or the organisation’s executive lead. The authorisation process also requires that the accountable signatory quality assures the report before it is submitted to the independent author.

The IMR author is responsible for completing the chronology of events (Appendix 6) based on agency’s involvement in the case. The information needs to remain brief and concise.

In preparation for writing the learning report the IMR author needs to familiarise themself with local policies and procedures including any relevant partnership policies and procedures, these will be used to cross reference events against the relevant policy or procedure guidance. Where the LRA feels that

additional specialist or specific information is required they will interview the relevant staff members to clarify these points.

**iix) Interviewing staff**

Interviewing the staff members needs to be managed with sensitivity allowing the interviewee to be accompanied if they wish, and to make it clear the purpose of the interview is not to apportion any blame, but to fully understand the events so that practice improvement and learning can be made. A documentary record of the interview should be taken and shared with the interviewee and any others present. Staff members should not however be interviewed if to do so compromises any ongoing police investigation. The LRA is responsible for collating and analysing all the information gathered during their preparation. A report including the recommendations will be produced (appendix 7) which includes the details of this desk-based review and the interviews.

1. **Adult(s) at Risk, Family and Significant Others**

These individuals provide a vital contribution to the intelligence gathering process. This is an integral component of the review process which needs to be handled sensitively if it is to be of mutual value to all involved. The PRG will nominate a member(s) to offer a meeting with the relevant individuals to explain the SAR process and to provide an opportunity for them to share their views. This meeting can also be used to signpost these individuals to other sources of support and advice which they may need as a consequence of their experience. Partners meeting adults at risk may wish to share the ‘Information for individuals’ ([Appendix 3](#Appendix3)). The PRG will keep these individuals regularly updated of progress. When the SAR reaches its conclusion and been approved by the Independent Chair of CSAB, the chair will offer to meet with these individuals to discuss and explain the conclusions of the review.

**11. Learning across the region**

The West Midlands Region is committed to sharing learning from Safeguarding Adult Reviews so that lessons can be learnt and action taken to prevent and protect adults with care and support needs. A West Midlands Regional SAR databank will be set up for the notification and keeping of all SARs carried out in the West Midlands region.

Each SAB will:

• Notify the West Midlands Regional SAR databank when a SAR is commissioned

• Inform the West Midlands Regional SAR databank when a SAR is completed

• Provide the West Midlands Regional SAR databank with information to enable regional learning

• Make available a copy of the SAR report for posting on the West Midlands Regional SAR databank

**12. Resolving disagreements**

It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is outside the provider’s area. If that is the case, a SAR should be carried out by the Board that is responsible for the location where the serious incident took place. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority.

Safeguarding Adults Boards can co-commission a SAR and can negotiate who should take the lead which will be determined by the individual case.

If agreement cannot be reached on the requirement for a SAR to be undertaken then this will be resolved in the first instance by the Chair of the Safeguarding Adult Board/s. If agreement can still not be reached this should be escalated to the Local Authority Chief Executives.

As a last resort a complaint can be made to the Local Government Ombudsman (LGO) if the complainant:

• disagrees with SAB decision to not undertake a Safeguarding Adult Review

• Has concerns regarding the decision of a SAB or outcome of a Safeguarding Adult Review

• Has concerns about the makeup of the SAR and potential conflict of interest

• is concerned the Chair of the SAB is also the chair of the SAR

• is unhappy with the conduct of a professional on a SAB who is employed by a body that falls outside the LGO’s jurisdiction.

## 13 Governance

Due to the complexity and the sensitive nature of the SAR process it is essential that they are managed within an explicit governance framework.

**Governance Reporting Framework**

• Each agency will be responsible for taking the report through it’s own governance structure.

• For the Walsall Safeguarding Partnership the report will go through the following governance for sign off:

* For reviews where a panel is convened the Review Panel
* PRG
* Operations and Scrutiny Committee
* Statutory Safeguarding Partners Executive Group

## 14. The SAR Checklist

Whichever model/approach used there are a number of key considerations. This framework has been developed to help to decide the most effective and efficient way to identify learning for families, organisations and the Board. Some of the elements below are mandatory and others are optional.

|  |  |
| --- | --- |
| **Terms of**  **Reference**  **Mandatory**  **Essential** | Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken.  Well formulated terms of reference are essential to ensure that the review is:  • Thoroughly scoped  • Manageable  • Conducted by the appropriate people  • Within agreed timeframes.  − To establish facts of the case  − To analyse and evaluate the evidence  − To risk assess  − Make recommend  Ensure the review will answer “THE WHY” question |
| **Interface with**  **other review**  **processes**  **Mandatory**  **See appendix 1** | Before starting a SAR identify if there is any links to other reviews and identify which takes priority. For example:  • DHR  • Children’s SCR  • Serious Further Offence Review (Probation)  • Mental Health Review  In addition - Consider previous SAR’s – will a recent SAR reinforce the same learning or is new learning to be identified? |
| **Family &**  **significant**  **others**  **involvement**  **Mandatory** | Identify the degree to which victims/families will be involved in the review and how they will be informed of this review.  Victims/families (family members who have played a significant role in the life of the service user) should be notified that the review is taking place. Involvement can be:-  • Formal notification only  • Inviting them to share their views in writing or through a meeting.  The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.  Victims/families should be offered support. |
| **Independent**  **Advocacy**  **Mandatory** | The local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding adult review. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 then, unless inappropriate, the same advocate should be used.  It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process |
| **Chair**  **Mandatory** | Each SAR will require a skilled and competent Chair of the panel considering the SAR, receiving Independent Management Reviews (IMR) and agreeing the report and recommendations.  When identifying who to chair the panel – consider:  • Are they independent of the case?  • In single agency reviews – are they independent of the single agency that it involves?  • Do they need to be independent of the SAB?  • What skills, knowledge and expertise do they specifically need? |
| **Panel**  **Mandatory** | Each SAR should be presented to a panel for scrutiny.  The panel should be made up of a minimum of 3 people excluding the chair.  They must be:  • independent of the IMR authors  • Independent of the case  • Knowledgeable of the issues/subject area. |
| **Practitioner**  **involvement**  **Mandatory** | Practitioners will be involved in all SAR’s – however the level of their involvement can be varied.  The following should be considered:  • Interviewing and taking a statement from practitioners for IMR’s can result is staff having heightened anxiety.  • Practitioners must be offered support throughout a SAR.  • Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome.  Multi agency learning events that involve practitioners can:  • Be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event.  • Assist practitioners to contextualize what happened and achieve closure.  • Result in quicker and more enhance learning |
| **Overview Report**  **& Executive**  **Summary**  **Mandatory** | An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced.  An Executive Summary may also be commissioned.  All reviews of cases meeting the SAR criteria should result in a report which is published and readily available on the SABs website for a minimum of 12 months. Thereafter the report should be made available on request. Do we want to add a retention timescale. This is important to demonstrate openness, transparency and candour and to support national sharing of lessons. From the start of the SAR the fact that the report will be published should be taken into consideration. SAR reports should be written in such a way that publication will be likely to harm the welfare of any adult with care and support needs or children involved in the case. Exclusion to this rule would be single agency reviews if individuals can be identified.  Final SAR reports should:  • provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;  • The type of abuse or neglect being considered.  • Be written in plain English and in a way that can be easily understood by professionals and the public alike; and  • Be suitable for publication without needing to be amended or  redacted. |
| **Independent**  **Author**  **Optional** | In the following situations it may be beneficial to consider an author who is NOT the chair:  • Very difficult and complex cases to enable the chair to concentrate in chairing  • Due to the specialist nature of the subject.  • To enable the chair to be from the SAB and be the chair as part of his day to day work.  An independent author must be:  • Independent of the case  • Independent of the organisations involves  • Appropriately skilled and competent.  They may also be independent of the SAB. |
| **Experts**  **Optional** | Consider if an expert is required to help to fully understand the situation and IMR findings.  If possible, identify which expert will be needed or may be needed at the start of the process. However, experts can be called upon at any time during the process |
| **Chronology**  **Optional** | A chronology can provide a timeline – a sequence of events.  A clear chronology of events in a safeguarding case can show agencies where risks and can be used to cross reference significant events.  If using a chronology, consider:  • The timeframe  • What you mean by key/significant events  • Using an agreed terminology avoiding abbreviations – for example Nurse A in one organisations chronology may not be the same Nurse A in another organisation’s chronology.  For complex cases it is recommended a Chronolator tool is used. |

**References:**

Care Act 2014

Department of Health (October 2014) Care and Support Statutory Guidance –

issued under the Care Act 2014.

Social Care Institute for Excellence (2015) Safeguarding Adults Reviews

under the Care Act – implementation support.

Warwickshire Safeguarding Adults Partnership – Safeguarding Adults Review

(SAR) Protocol and Guidance

London Joint Improvement Programme: Learning from Serious Case Reviews

on a Pan London Basis, Sue Bestjan, March 2012

**Appendix 1: SAR Referral Form**



**Appendix 2: Scoping Document**



**Appendix 3: Information for Family, Friends & Carers**



**Appendix 4: SAR Process Flow Chart**

