Harrow Safeguarding Adults Board

Safeguarding is everyone's business

Safeguarding Adults Review Policy and Procedure

Contents

Revision Number	Date Approved by the Board	Links to Other Policies	Review Date:
1	22.05.2024 – SAR CR Group		July 2024 - HSAB

1. Introduction

The Safeguarding Adults Board (HSAB) is the statutory body that sets the strategic direction for safeguarding, and is responsible for protecting adults who are experiencing, or who are at risk of abuse or neglect living in the Borough of.

The Care Act 2014 outlines the circumstances in which Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR). The Care Act further placed a duty on all Board members to contribute to the undertaking of such reviews.

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. The Care and Support Statutory Guidance issued under the Care Act 2014[1] (Statutory Guidance) by the Department of Health also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

2. Purpose

The purpose of this policy is to outline the principles and definitions that support the commissioning and undertaking of Safeguarding Adults Reviews and to describe the statutory duties set out under Section 44 of the Care Act 2014. This policy is underpinned by the London Multi-Agency Adult Safeguarding Policy and Procedures[2].

3. Scope

The safeguarding duties apply to any adult who:

a. has needs for care and support (whether or not the local authority is meeting any of those needs) and;
b. is experiencing, or at risk of, abuse or neglect; and
c. as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

This definition of adults at risk of abuse or neglect includes:

- Those who are at a greater risk of suffering abuse or neglect because of physical, mental, sensory, learning, or cognitive illnesses or disabilities; and substance misuse or brain injury.
- Those who purchase their care through personal budgets, those whose care is funded by local authorities and/or health services and those who fund their own care.
- Informal carers, family and friends who provide care on an unpaid basis.

[1] Care Act 2014 - Care and Support Statutory Guidance

[2] Section 2.9 of the Safeguarding Policy and Procedures specifically covers SARs

4. Policy Statement

The HSAB works in partnership to safeguard and promote the well-being and independence of adults living in the Borough who are experiencing, or at risk of abuse or neglect. It further seeks to examine lessons learned as a result of SARs undertaken both locally and nationally. These lessons will be used to help improve the approach taken in Harrow to better protect adults from either the risk of, or the experience of abuse or neglect.

5. SAR Criteria - Legal Framework

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards must (Mandatory SAR) arrange a Safeguarding Adults Review when an adult in its area dies (including suicide) either 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; or if an adult has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

The Act further defines that 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.

The Care Act 2014, Section 44(4) also states that SABs are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support; when it is clear there is potential to identify "sufficient and valuable learning" to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future (Discretionary SAR).

This policy has been developed within the context of the law and guidance that seeks to protect adults including (but not exhaustive):

- The Care Act 2014
- Care Act 2014 Statutory Guidance
- Data Protection Act 2018
- The Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards)
- The Human Rights Act 1998
- The Equality Act 2010
- Mental Health Act 1983 and the Code of Practice 2015
- Serious Crime Act 2015
- Modern Slavery Act 2015
- Criminal Justice and Courts Act 2015
- Statutory Guidance on Female Genital Mutilation
- Domestic Abuse Act 2021

Further links to useful websites can be seen on page 17.

6. Information Sharing

The Care Act 2014, Section 45 creates a legal duty for any agency or person to share what they know with the Safeguarding Adults Board (SAB). The test is that the information requested by the SAB must be for the purpose of enabling or assisting it to perform its functions, including that of undertaking **Safeguarding Adults Review**. This means that if a SAB requests information from an organisation or individual who is likely to have information, which is relevant to the SAB's functions, they **must share** what they know with the SAB.

During the course of a SAR agencies and professionals will be asked to share information securely with the reviewer, as directed by the HSAB Business Unit (in line with s.45 of the Care Act 2014 outlined above). The reviewer will collate this information and present the initial findings with participants prior to then sharing a draft report with those directly involved, to allow them to check for accuracy and give their input in developing the content, and the recommendations. These documents must not be shared more widely without the express permission of the Case Review Sub-Group Chair, via the HSAB Business Unit.

7. Who this Policy applies to

This policy applies to all partners of the HSAB who have collective responsibility for ensuring that the Board is able to meet its statutory duties. Specific detail of the partnership is outlined in the HSAB Compact and Strategic Business Plan.

8. National Relevance

SARs may also identify issues of national relevance, good practice, and lessons that can be broadly applied outside Harrow. Whenever there is an issue of national importance to central government departments or regulatory bodies, the SAB should initiate discussions in line with the National Escalation Protocol.

9. Parallel Processes

A SAR is not designed to hold any individual or organisation to account, establish how someone died or was harmed, or undertake human resources duties as other processes exist to address those issues. The SAR process is also not intended to duplicate or replace other agencies own internal or statutory review procedures to investigate serious incidents, or their own mechanisms for reflective practice. There is no requirement that any parallel process (including a Safeguarding Enquiry undertaken in line with s.42 Care Act 2014) is completed before a SAR can commence.

A number of processes can run in parallel to a SAR, including but not limited to:

- Employment and regulatory investigations and disciplinary proceedings, including referrals to the DBS
- Coroner's Inquests and the Medical Examiners process.
- Criminal investigations.
- NHS Patient Safety Incident Response Framework (PSIRF)
- Learning Disability Mortality Reviews (LeDeR)
- Child Safeguarding Practice Reviews
- Domestic Homicide Reviews
- MAPPA Serious Case Reviews
- Mental Health Homicide Reviews or NHS Independent Investigation Reports

Where there are parallel processes, the SAB should address these within the SAR Terms of Reference and explain how the process will dovetail with other relevant investigations to avoid as much as possible; duplication of effort, prejudice to criminal investigation and or trials, unnecessary delay, and confusion to all parties, including staff, the person, and their family.

It will be the responsibility of the SAB Business Manager, in consultation with the SAB Chair, to contact the relevant partnership or agency to ensure there is effective co-ordination:

- With the Police Senior Investigation Officer, where there are parallel criminal investigations.
- With the Coroner's Office in relation to any ongoing processes.
- Where the subject of a SAR was in Harrowto receive care or treatment with any relevant commissioning authority (e.g. NHS England, or the local authority or Integrated Care Board (ICB) where the adult was ordinarily resident). In such incidents, that area's SAB should also be notified and cooperate across boundaries with requests for information, as detailed within the ADASS Safeguarding Adults Policy Network Guidance.

10. Principles

This policy reflects the six safeguarding principles described in the Statutory Guidance that underpin all adult safeguarding work, and which applies to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. These principles are as follows:

Empowerment
People being supported and encouraged to make their own decisions and informed consent. "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention
It is better to take action before harm occurs. "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality
The least intrusive response appropriate to the risk presented. "I am sure that the professionals will work in my interest, as I see them and they will only be involved as much as needed."

Protection
Support and representation for those in greatest need. "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability
Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life and so do they.”

In addition, the Statutory Guidance outlines a number of principles to be followed by Safeguarding Adults Boards and their partner organisations when undertaking Safeguarding Adults Reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the well-being 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 level of complexity of the issues being examined.
- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

11. Key Roles and Responsibilities

The Independent Chair of the Harrow Safeguarding Adults Board
The Independent Chair has responsibility for:

- Ensuring that the HSAB meets its statutory responsibilities and reporting on the discharge of these functions (including ongoing cases) at every Board meeting.
- Making a decision in response to any recommendation for a Safeguarding Adults Review by the HSAB Case Review Sub-Group.
- Appointing suitable independent individuals to lead the SAR, who should have the required level of objectivity to ensure openness and transparency.
- Considering whether an outside expert(s) should be consulted to help understand any specific aspects of the case.
- Obtaining legal advice for any specific elements of the review as required.
- Agreeing the scope, terms of reference, methodology and funding for the SAR.

Harrow Safeguarding Adults Board
The Harrow Safeguarding Adults Board has responsibility for:

- Identifying appropriate individuals from their own agencies to be involved in the process. This is vitally important and will ensure that information is shared appropriately following the guidance in this document.
- Receiving/considering regular reports on progress from the SAR Sub-Group.
- Considering and approving final review reports.
- Agreeing the process for dissemination of the review.
- Agreeing and ensuring that multi-agency action plans resulting from SARs and other forms of review are implemented.

Case Review Sub-Group
The HSAB Case Review Sub-Group has responsibility for:

- Considering all SAR notifications.

- Making recommendations to the HSAB Independent Chair on the delivery of SARs.
- Making recommendations on the appropriate type of review and where responsibility rests for leadership, oversight, and co-ordination of the chosen review process.
- Fulfilling the statutory duty of the HSAB in respect of Safeguarding Adults Reviews and ensuring that SARs are completed in line with this SAR Policy and Procedure.
- Making recommendations about how the adult and/or their representative should be involved including whether or not they need an advocate.
- Ensuring that the reports from all reviews, together with a recommendation on action planning, are presented to the HSAB for approval.
- Regularly reporting progress against the agreed action plans to the HSAB.
- Working closely with other Sub-Groups/ Task and Finish Groups to ensure that any recommendations from a review are fully implemented.
- Ensuring that any lessons learned from local, regional, and where appropriate, national SARs and other forms of review are disseminated throughout the HSAB partner agencies.

Safeguarding Adults Review Panel
The SAR Panel is the group that is set up to oversee the delivery of every specific review. In most instances this may compromise the core membership of the Case Review Sub-Group, although other partners/agencies and professionals may be approached to provide further expertise if required.

The Safeguarding Adults Review Panel has responsibility for:
- Undertaking the SAR in accordance with the agreed scope, terms of reference and methodology.
- Considering how the interface between other reviews and parallel proceedings should be managed.
- Ensuring that the SAR Panel has the necessary expertise to oversee and contribute to the review process based on the particular aspects of the case.
- Ensuring appropriate involvement of professionals and organisations that were involved with the adult.
- Taking account of the legal advice provided in relation to any aspect of the review.
- Considering how best to liaise with and involve the adult and/or their representative.

Staff Involvement
As soon as a SAR has been agreed, staff and volunteers that have had involvement in the case should be notified of this decision by their agency lead (HSAB Board member). The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers and their line managers. It should be made clear that the review process can be lengthy.

It is important that all relevant staff and volunteers of agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and practitioners involved in a SAR to “tell it like it is”, without fear of retribution, so that real learning and improvement can happen.

Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offered specific support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers and needs to be

acknowledged by the agency, who should have appropriate ways to offer support for those who may have witnessed traumatic incidents[3]. The impact may also be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace Involvement of the Adult, Family Members and Representatives

12. Involvement of the Adult, Family Members and Representatives

Discussion should take place at an early stage with the adult and/or their representative to agree if and how they wish to be involved in the process, using the principles of Making Safeguarding Personal (MSP). Where the adult has the mental capacity to engage with the review, the involvement of family or informal carers should be agreed with the adult. In any case where the adult does not have the necessary mental capacity at that time; family or informal carers must be consulted in accordance with the Mental Capacity Act 2005.

The Local Authority has a duty to involve an appropriate person, which could involve the use of Care Act Advocacy (see below), to facilitate an adult's involvement in the safeguarding adult process if it is deemed that they "would have substantial difficulty in participating themselves" (Statutory Guidance).

Advocacy
As part of the safeguarding adult procedure, consideration must be given as to whether the adult may benefit from the support of an independent advocate. Where the adult has substantial difficulty in participating in the safeguarding adult process (and there is no other appropriate person to assist them), the Local Authority must arrange that independent advocacy. Where an Independent advocate has already been arranged under Section 68 of the Care Act 2014, or under the Mental Capacity Act 2005, the same advocate should be used unless for good reason, this is deemed to be inappropriate.

Reasonable and appropriate support and adjustments should be also made by HSAB as required to enable the adult(s), their family and/or representatives to participate in the SAR. This may include, but is not limited to:

- Easy read, large print and/or translated materials.
- Access to an interpreter.
- Support from a chosen chaperone or representative.
- Longer meeting times.
- Pre-meeting briefings and post-meeting de-briefs.

13. Links to Other Statutory Reviews

When a SAR Notification potentially overlaps with a Child Safeguarding Practice Review (CSPR) or a Domestic Homicide Review (DHR); then the Independent Chair should work with the Chairs of the Harrow Safeguarding Children Board and Safer Harrow Partnership Board to decide which process should take precedence.

Decisions on conducting SARs should also take into consideration how this may be affected by other parallel proceedings such as criminal investigations and court hearings, coroner's inquests and hearings or Independent Office for Police Conduct investigations (IOPC).

[3] Health and Safety Executive: Violence and aggression at work - Reporting and learning from incidents

In such circumstances the HSAB Independent Chair should seek advice from the police and the Crown Prosecution Service if appropriate on if, and how, the Safeguarding Adults Review should take account of any criminal investigation or proceedings. They should establish if the Safeguarding Adults Review may have any prejudicial impact upon any such investigations or proceedings, and as such, if a SAR should not start until after the proceedings are completed, or if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings.

More broadly the HSAB Independent Chair should also take into account the advice of the Case Review Sub-Group and SAR Panel, including legal and other expert advice, before deciding if a review can commence or continue.

Child Safeguarding Practice Review (CSPR)
A SCPR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. A SCPR should take place if abuse or neglect is known, or suspected to have been involved and:

- A child has died, or a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child.
- The child dies in custody.
- A child died by suspected suicide.

More information can be found at: HSCB Child Safeguarding Reviews

Domestic Homicide Review (DHR)
A Domestic Homicide Review incorporates a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself with a view to identifying the lessons to be learned from the death.

Statutory guidance has been issued by the Home Office under section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

14. Duty of Candour

Secondary Care Providers registered with the Care Quality Commission are subject to a statutory Duty of Candour when they are carrying on a regulated activity (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20). The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The Harrow Safeguarding Adults Board is committed to supporting the principles outlined in the Duty of Candour when undertaking all safeguarding activity, and as such, the Board will work with partners and agencies engaged in SAR activity to comply with these regulations.

15. Timescales

The Harrow Safeguarding Adults Board is committed to completing Safeguarding Adults Reviews in a timely manner and “in any event, within six months of initiating it unless there are good reasons for a longer period being required” (Statutory Guidance). This could include for example, the need to delay the process due to legal proceedings or to any relevant circumstances surrounding the adult.

16. Findings from Safeguarding Adults Reviews

In accordance with the Care and Support Statutory Guidance, all Safeguarding Adults Review Reports “should be written in plain and easy to understand language, provide a sound analysis of what happened and why; and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence” (Statutory Guidance).

All Safeguarding Adults Reviews conducted within the year must be referenced within the HSAB Annual Report, together with any actions that it has taken or intends to take in relation to
implementing the lessons learned from SARs. The Annual Report must also include the reason for any decision where the HSAB decides not to implement an action.

The Harrow Safeguarding Adults Board will retain the intellectual property rights in relation to all reviews undertaken.

17. SAR Notifications

Notifications should be made using the dedicated SAR Notification Form which is available as a standalone document on the Board’s website: Harrow SAR Notification Form

Notifications must be fully completed, include relevant and factual information, provide contact details for all agencies involved, and give a full description of how the case meets the criteria outlined on the form. Notifications should ideally be quality checked by the partner agencies designated Board member before submission.

Notifications from non-board member agencies should also be made using the online Notification Form, which can also be used by an adult or family member, although it is preferable that the HSAB Business Manager should be initially contacted to discuss the matter under these circumstances to give advice on the Care Act criteria: HSAB@harrow.gov.uk

Professionals can also seek advice prior to submitting a SAR Notification Form if they are unsure if the case, they are considering meets the criteria.

Notifiers will receive an email from the HSAB Business Unit to receipt their SAR Notification.

Once the Notification has been made the HSAB Business Manager will triage this to ensure that this has been fully and appropriately completed. If not, this may be referred back to the Notifier for further information, or if this clearly does not meet the SAR criteria then this will not be taken forward to the Case Review Sub-Group for their consideration. If this is the case, then the Notifier will be informed of this by the HSAB Business Manager in a timely manner.

If the information provided in the Notification is still not conclusive, then the initial scoping/ chronology information may be requested (in consultation with the SAB Chair) before this is presented to the Case Review Sub-Group for consideration.

This information will be collected in a timely manner.

18. Consideration by the Case Review Sub-Group

The Case Review Sub-Group meets regularly throughout the year (every 6-8 weeks) to ensure that SAR Notifications are considered in a prompt manner.[4]

All relevant agencies will be invited to attend the relevant Sub-Group meeting to present and consider Notifications, including the referrer wherever possible or applicable. Members of the Sub-Group will be sent all of the relevant paperwork in advance of these meetings for their consideration, which may include the initial scoping/chronology information when it is deemed necessary.

The Chair of the Case Review Sub-Group Meeting should be independent of the referring agency (including the local authority)[5]. An alternative Chair can be appointed to replace the substantive Chair of the Case Review Sub-Group if this is appropriate.

19. The HSAB Independent Chair

The HSAB Independent Chair should be advised of the date of the meeting, although it is not expected that the Independent Chair will be in attendance at these meetings unless it is deemed to be necessary.

20. Decision Making

The information contained on the notification should be considered by the Case Review Sub-Group and a decision made using this Policy and Procedure, alongside the Statutory Guidance, as to whether:

a) The criteria for a mandatory SAR are met.
b) There is sufficient merit to the notification that a discretionary SAR should be conducted.
c) There is a need to gather more information to support the decision-making process.
d) The criteria are not met but another type of non-statutory review would be appropriate.
e) The criteria are not met and no further action is to be taken.

The Case Review Sub-Group should also take into account:

- Whether any other Statutory Review Processes are taking place (CSPR or DHR).
- Whether any other significant processes are taking place (Police Investigation, Coroner's Inquest).
- What potential impact a SAR may have upon such investigations or proceedings, including whether a SAR should not start until after the proceedings are completed, or

[4] Further exceptional meetings can be arranged, if necessary, at short notice.

[5] As of October 2023, the Independent Chair is also the Chair of the Case Review Sub-Group.

if the SAR is already underway, whether it should be delayed until after the outcome of the criminal proceedings.

- If there is a delay in the commencement of a SAR, then the Case Review Sub-Group Chair will ensure that any learning at this stage of the process is identified and shared with relevant parties.

In making a decision to recommend that a SAR is conducted the Case Review Sub-Group Chair and group members should aim to generate a 'consensus', not a majority view. If the group cannot come to a consensus, the final decision will rest with the Chair of the Harrow SAB after carefully considering the views of all panel members. The Independent Chair may wish to seek peer challenge from another SAB Chair when considering this decision.

If the criteria are not met, but another type of case review is felt to be appropriate, the Case Review Sub-Group should recommend which type of review would maximise learning. Other types of review may include a Lessons Learned Review, Management Review, Single Agency Review, or a Reflective Practice Session (this list is not exhaustive).

The referring agency/person will be informed of the decision in writing by the Independent Chair, and discussions should be held on how to inform the adult and/or their representative if there is to be a SAR which will be confirmed in writing. The adult and/or their representative will not to be informed if there is not going to be a SAR unless there are exceptional circumstances.

Where another type of review takes place the HSAB will receive a report on the findings and any recommendations made and help to monitor the delivery of any action plan.

If a request for a SAR is declined, and where the Notifier is dissatisfied with this outcome, they should notify the Chair of the HSAB in writing (via the HSAB Business Manager) who will discuss this with the Notifier and ask the Case Review Sub-Group to review this decision if appropriate.

If a decision not to hold a SAR is upheld, the requesting agency can choose to take no further action or to undertake an internal review using an appropriate methodology - some options are set out in the London Multi-Agency Safeguarding Adults Policy and Procedures.

21. The Relationship Between Section 42 Enquiries and SAR's

Section 42 Enquiries are undertaken when an adult with care and support needs has been identified as experiencing, or at risk of abuse and neglect. As a matter of law an enquiry under Section 42 cannot commence in relation to a person who has died. Where someone's death is suspected to be as a result of abuse or neglect and the statutory criteria appear to have been met under Section 44, then a SAR Notification should be submitted as outlined above.

If the circumstances of the death mean that there are reasons to be concerned about risks to 'other adults', Section 42 Enquiries may need to be made to decide whether action needs to be taken to protect them. For example, this will often be necessary following a death in an organisational setting where other adults are continuing to receive a service.

SAR Notifications can also be made in cases where someone is known or suspected to have suffered "serious abuse or neglect" (see Section 5, page 4).

The Statutory Guidance gives as examples of serious abuse or neglect cases where an adult "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". In this case, Section 42 Enquiries into what happened to that person may still need to take place in parallel, to ensure the person's immediate safety and the safety of any others who may be at risk. This enquiry should be limited to those purposes rather than duplicating what may take place through the process of a SAR.

22. Terms of Reference

The scope and terms of reference should be proportionate to the nature of the case and should identify what appear to be the most important issues to address in identifying the learning from the case.

The Terms of Reference (ToR) will:

- Determine the timeframe during which events in the adult's life will be reviewed, taking into account the circumstances of the case.
- Clearly highlight the key questions that the review should aim to answer.
- List the agencies and individuals who should be engaged in the review.
- Illustrate which pieces of legislation, policies and strategies should be considered as part of the process.
- Consider if there are any specific considerations around equality and diversity.
- Outline the methodology to be used.
- Reflect Data Protection Act requirements and outline the arrangements for storage and transfer of personal information.
- Consider how the review process should take account of previous lessons learned both nationally and regionally, including reference to the national SAR Thematic Analysis.
- Include a duty to report information to the Independent Chair if new information comes to light suggesting malpractice of individuals and/or organisations.
- Consider how matters concerning family and friends, the public and media should be managed before, during and after the review.
- Consider how to liaise with the adult and whether they require an advocate to support them.
- Ensure that any learning identified at an early stage of the process is shared and acted upon.

The process for undertaking SARs (the methodology) will be determined by the Case Review Sub-Group who will consider this whilst the ToR is being drafted, and in consultation with the reviewer.

No one model will be applicable in all cases, and a hybrid model may be the most appropriate method in the majority of cases. The "focus must be on what needs to happen to achieve understanding, remedial action and answers" (Statutory Guidance).

23. Outline of the Process

The process will be supported throughout by the HarrowSafeguarding Adults Board Business Unit. The Business Manager will specifically act as the commissioning authority for the reviewer providing support and oversight to the contractual arrangements.

Some or all of the following actions/stages will be appropriate dependent on which methodology is being followed and will be determined by the Independent Reviewer and the SAR Panel:

1. Identify the evidence required from each agency.
2. Produce Individual Management Reviews (IMRs).
3. Produce a chronology of events.
4. A review and analysis of the relevant evidence.
5. Hold a practitioner event to consider what happened and why, areas of good practice, areas for improvement and lessons learned.
6. Formulate a SAR Report with analysis of key issues, lessons learned and recommendations.
7. Produce an action plan in response to the lessons learned.
8. Agree how the learning will be disseminated, including providing feedback to staff and agencies involved in the case, and the delivery of a learning event.
9. Publish a '7-minute briefing' for a wider audience to share the lessons learned from the case.

Liaison should take place with the adult, their advocate, relative or carers throughout the process and regarding the publication of the final report.

The Case Review Sub-Group Chair should report regularly on progress to the HSAB.

Discussion will take place with the adult and/or their family regarding the use of pseudonyms within the report, or if the adults actual name should be used.

The Lead Reviewer should present the Final Report to the Case Review Sub-Group.

The Independent Chair will determine how the final SAR report, recommendations and action plans are to be presented to the HSAB.

A reason should be given for any decision where the HSAB decides not to implement a recommended action.

24. Publication of SAR Reports

A SAR report will normally be drafted for all reviews unless there are exceptional circumstances preventing or precluding the need for this.

The requirement for this should be set out in the Terms of Reference as agreed by the Chair of the Harrow Safegaurding Adults Board and Case Review Sub-Group.

The Case Review Sub-Group must ensure that there is sufficient reflective analysis, scrutiny, and evaluation of evidence by the reviewer and 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.

The Case Review Sub-group should receive and agree the draft report before it is presented to the HSAB, so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented.

The adult(s) and/or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process.

Whilst there is no legal duty to publish a full SAR report, consideration will be given to the wider public benefit of doing so.

If the final report is published into the public domain, this will be via the Harrow Safeguarding Adults Board (SAR pages), and a copy of the report will be made available to the National Network's SAR Library. A copy of the Report will be retained by the SAB (or local authority under s.43 Care Act) for a minimum of 20 years following the publication of the SAR. This takes into account that the information might: be required to protect other adults at risk; need to be accessed by the data subject at a later date; or be subject to future investigations, inquiries, and litigation).[6]

The decision to destroy or further retain records relating to a SAR will be approved by the SAB (and supported by legal advice. If the decision is to proceed with destruction, all agencies who may be retaining duplicate records will be notified in order for them to consider whether to delete or amend their own records. The HSAB Information Sharing Agreement should be followed in relation to the secure storage and transfer of information relating to the SAR.

The HSAB 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. Considerations of confidentiality, parallel proceedings or other legal reasons may affect decisions to publish. Any reports to be published must be fully anonymised unless the adult(s) and or family members, or their representatives, agree that the adult(s) first, last or both names can be used. In any event the decision to anonymise the report if this deemed to be necessary rests with the HSAB Independent Chair.

SABs are not legally bounded by the Freedom of Information Act (FOIA) 2000, although Council's as statutory partners of SABs are. The HSAB will support the Local Authority as far is reasonable within the constraints of confidentiality with any FOIA requests. However, all Safeguarding Adults Reviews conducted within the year will be referenced within the Board's Annual Report to help satisfy FOIA requests, which should include the reason for any decision where the HSAB decides not to implement an action.

25. Quality Assurance

[6] In the absence of legislation or regulation, the designated retention period has been informed by the Health and Social Care Records Retention Schedule which states that "The retention periods listed in this retention schedule must always be considered the minimum period. With justification, a retention period can be extended for the majority of cases, up to 20 years" AND the R v Northumberland County Council and the Information Commissioner (23 July 2015) judgement which provided assurance that it is legitimate to vary common practice and guidance where there is a well-reasoned case for doing so.

Quality assurance is embedded throughout the SAR process from developing the Terms of Reference, commissioning a reviewer, through to the SAB scrutiny of the report and the implementation of the recommendations. The Social Care Institute of Excellence (SCIE) Quality Markers are used to underpin this approach.[7]

The SAR report must provide a robust assessment and analysis of the evidence (working out) for the SAB to be able to check, scrutinise and critically analyse the content. In doing so, the SAB will gain assurance of the adequacy of the report and usefulness of the recommendations.

26. Monitoring of Action Plans

Arrangements for the monitoring of actions plans which are derived from SAR recommendations should be put in place as follows:

- Board members of the HSAB are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.
- The Case Review Sub-Group will monitor progress on all recommendations and may request periodic progress update reports from relevant agencies, until such time that all actions have been completed.
- A report on the implementation of action plans across partnerships to be given to the HSAB at Board meetings.
- Liaison to continue to take place with the adult and/or their representative as appropriate.

27. Sharing Learning from SARs

Responsibility for Practitioner and multi-agency Learning Events and briefing materials such as 7 Minute Briefings, Case Summaries and case Factsheets shall remain with the Harrow Safeguarding Adult Review Case Review Subgroup (SAR CR Group).

Where SAR Recommendations or strategic actions encompass broader, systemic workforce development or training needs, the SAR CR Group Chairperson will liaise with the Harrow Learning & Development Subgroup Chair to agree cross-allocation of structural learning activities arising from a SAR that will be undertaken by the Learning & Development Subgroup.

28. Links to Other Websites

- SARs: SCIE Guidance
- National SAR Library
- National Analysis of Safeguarding Adults Reviews

[7] SCIE - Safeguarding Adults Review Quality Markers

Annex 1: Guidance for Authors of Individual Management Reviews (IMR's)

Background
Each agency that has been involved in the case under review should, when requested, undertake an Individual Management Review (IMR) of its involvement.

What is an Individual Management Review?
Individual Management Reviews (IMR's) are a way of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. Every organisations IMR should identify good practice alongside the identification of areas where systems, processes, or individual/organisational practice could be improved.

The IMR process is not designed for identifying gaps in the actions or activities of other organisations.

IMR's are used as one of the main sources of information for a Safeguarding Adults Review.

Principles
Individual Management Reviews should be:

Systemic– Considers the influence of systems - how services are set up and provided, rather than solely individual actions.
Proportionate – Succinct and focused on the key lines of enquiry and relevant detail.
Independent – Completed by someone who has not had prior involvement or case supervision responsibilities.
Transparent – Open and honest in presenting and analysing the agencies involvement.

Individual Management Review Process

When undertaking an IMR the following process should be followed:
- Collate information (reading records, interviews etc.)
- Analysis followed by identification of good practice and areas for improvement
- Identify findings and recommendations
- Report writing
- IMR Approval

Collating information
Explore a wide range of information from the sources available in order to carry out the analysis required.

Chronology
The Individual Management Review must be accompanied by a detailed chronology of contact with the adult for the time period identified for the Safeguarding Adults Review. A chronology of events is a useful way of achieving an overview of a case from information obtained from a number of organisations. This enables a review to identify gaps in service provision or practice, missed opportunities for communication and areas of good practice.

Also, identify key periods of the chronology where contact with the adult was felt to be significant to the care, support and treatment delivered, which could have affected the outcome of the case.

Content of Individual Management Review Reports
It is important that IMR authors do not assume that people who read their reports have any knowledge of the issues under examination. Consequently, it is important to ensure that the evidence, upon which conclusions and recommendations are drawn, is clearly stated. Try to get an understanding not only of "**what**" happened, but '**why**'. Never use abbreviations, jargon or initials.

Professionals Involved in the Care and Support of the Adult
Please list all professionals involved in the care and support for the adult at risk from your agency.

Factual / Contextual Summary
Please provide a brief factual and contextual summary of your agency's involvement with the adult at risk for the time period identified for the Safeguarding Adults Review.

Analysis of Involvement
In this section the author must review the information in the comprehensive chronology and produce a critical analysis. The information included and the analysis should be appropriately evidenced. Your analysis should not consist of a rewording of the chronology. It is important to critically analyse your agency's involvement.

Author's Considerations
Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgements, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what occurred, but why. Identify both good and poor practice, where performance exceeded or fell short of those standards expected in this type of case.

Identify what underlying factors were significant and how they affected the practice and decisions in this case, also whether these were multi or single agency factors (e.g. workload, resources, staffing issues, training, management, recording systems and information sharing arrangements).

Consider alternative courses of action and what would have made a difference to the adult.

You will be asked to complete the following questions:

- Were practitioners sensitive to the needs of the adults at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a Safeguarding Concern about an adult with care and support needs in these circumstances?
- Did the agency have in place policies and procedures for safeguarding adults at risk and acting on Safeguarding Concerns about abuse or neglect?
- What were the key relevant points/opportunities for assessment and decision making in the case in relation to these adults?
- Do assessments and decisions appear to have been reached in an informed and professional manner?
- Did action accord with assessments and decisions made?
- Were appropriate services offered/provided or relevant enquiries made in the light of assessments?

- Where relevant, were appropriate care plans in place, reviewing processes complied with, and how did they involve relevant risk assessment in protecting the adult at risk?
- Were more senior managers or other agencies and professionals involved at points they should have been?
- Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk of abuse and neglect, and wider professional standards?
- Was mental capacity considered and or any formal Mental Capacity Assessment conducted and recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the adult? If this was a relevant factor, was it cited and explored appropriately?
- Were relevant, appropriate safeguarding or care plans in place, and if so were these reviewed and complied with?
- Are there are any particular features of this case, or issues surrounding the death or injury of the adult(s), that you consider require further comment in respect of your agency's involvement?

Learning

- This section is where you will be able to explain what has been learned from the case.
- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there lessons from this case for the way in which this agency works to safeguard adults?
- Are there implications for ways of working?
- Are there implications for management and/or supervision?
- Are there implications for training (single or multi-agency)?

Recommendations for Action

In this section you will need to make recommendations on behalf of your agency.

Recommendations should be few in number, focused and specific, and capable of being implemented without delay. Consideration should be given to the resources required to implementing the recommendations such as cost. e.g.

- What action should be taken, by whom, and by when?
- What outcomes should these actions bring about?
- How will the agency review whether they have been achieved?

Quality Assuring Individual Management Reviews

Before the IMR report is provided to the safeguarding adults board it should be quality assured and agreed by a senior person within your organisation (preferably your organisations safeguarding adults board member) in line with your internal processes.

The purpose of quality assuring IMR reports is to promote consistency across organisation and ensure they are fit for challenge and scrutiny. The factors that an effective IMR will include are:

- A comprehensive chronology
- A clear history of our involvement
- Identification of strengths
- Critical analysis
- Well focused recommendations that are capable of being implemented without delay.