Merton Safeguarding Adults Board

London Boroughs of Merton

Safeguarding Adults Board

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

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

Previous Version	V3
Version	V4
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Next Review	March 2024

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Acknowledgements, context and local references

The Merton Safeguarding Adults Board (MSAB) would also like to thank, acknowledge and recognise the work of London Boroughs of Richmond and Wandsworth and the Richmond and Wandsworth Safeguarding Adults Board as a major source of this protocol and its content.

1. INTRODUCTION

1.1 Section 44 of the Care Act 2014 requires that Merton Safeguarding Adult Board (MSAB) are responsible for Safeguarding Adult Reviews (SAR). Paragraphs 14.162 to 14.179 of the Care and Support Statutory Guidance2 sets out in more detail the principles, definitions and outlines a framework for when certain events happen.

1.2 The MSAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The MSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. The specific criteria are set out in paragraph 4.2 and on Form A, Appendix 1 of this document.

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

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

1.5 This SAR Protocol has been developed by the London Boroughs of Merton MSAB to support the effective identification of and response to SARs within the Borough and to support the Board in discharging its statutory duty. The Protocol describes the process to follow and is informed by the statutory text and complements the Pan London Safeguarding Policy.

1.6 It is important to stress that a SAR is not a ‘second stage’ safeguarding process and is usually reserved for the most significant of issues.

1.7 The SAR subgroup will ensure that the Safeguarding Adult Review (SAR) Quality Markers are cross referenced throughout the SAR process. The SAR Quality Markers are a tool to support people involved in commissioning, conducting and quality-assuring SARs to know what good looks like. Covering the whole process, they provide a consistent and robust approach to SARs.

The Quality Markers are based on statutory requirements, established principles of effective reviews and incident investigations, as well as practice experience and ethical considerations. The SAR Quality Markers assume the principles of Making Safeguarding Personal, as well as the Six Principles of Safeguarding that underpin all adult safeguarding work (Empowerment; Prevention; Proportionate; Protection; Partnership; Accountable). These principles therefore permeate the Quality Markers explicitly and implicitly. (See Appendix 9)

2. SAFEGUARDING ADULT REVIEW OPERATING FRAMEWORK AND GOVERNANCE

2.1 The London Boroughs of Merton Safeguarding Adults Board (MSAB) has the lead responsibility for carrying out a Safeguarding Adult Review (SAR) based upon receipt of a referral (see below within the relevant section and within the appendices for supporting documentation).

2.2 The MSAB has delegated management of this responsibility to one of its subgroups, the Safeguarding Adult Review Sub-Group (hereafter referred to as the "Sub-Group") chaired by the Assistant Director of Adult Social Services and a representative from the MSAB leadership. The Sub- Group membership is made up of the statutory members of the MSAB (the Council, Police and Clinical Commissioning Group, Central London Community Healthcare NHS Trust, London Fire Brigade, St Georges University Hospital NHS Foundation Trust, Epsom & St Helier NHS Trust, Mental Health Trust) with specific Terms of Reference that are annually reviewed. It reports to the MSAB.

2.3 The Sub-Group meets on a planned basis throughout the year, but a meeting will be convened as soon as is practical upon receipt of a referral or an ongoing basis to act as a coordinating group to any SARs in progress.

3. PURPOSE OF A SAFEGUARDING ADULT REVIEW

3.1 The purpose of 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. It is not an enquiry into how a vulnerable adult died nor is it to apportion blame; but to learn from such situations, and that those lessons are applied to future cases to prevent similar harm occurring again.

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

3.3 It will be highly likely that a safeguarding process will have been followed in relation to the circumstances. The SAR is for consideration of the most serious issues and will not be an alternative to a safeguarding enquiry, investigation or process.

3.4 The purpose of conducting a SAR is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard vulnerable adults.
- Review the effectiveness of procedures and their application (both multi- agency and those of individual organisations).

• Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
• Prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

3.5 It is acknowledged that all agencies will have their own internal and/or statutory review procedures to investigate serious incidents. This protocol is not intended to duplicate or replace these, but it does remain a statutory requirement in its own right and will be complemented by other such processes.

3.6. Where there are possible grounds for other review processes to be activated (e.g. Domestic Homicide Review, Child Serious Case Review, Health Serious Incident, Mental Health Homicide Review, Root Cause Analysis or other) a decision should be made at the outset, by the lead decision makers of the respective review processes, about which process will lead and who will Chair, with a final joint report being taken to all the relevant review commissioning bodies. In this respect it is important for the SAR Subgroup to inform those responsible for any parallel processes that is SAR is to be conducted and for other reviewing bodies to likewise inform the SAR Subgroup of any processes they are required to or planned to be undertaken. However, it must be remembered a SAR is a statutory requirement and will be required to be undertaken as much as other processes.

3.7. LeDeR Reviews - The Learning Disabilities Mortality Review (LeDeR) programme is a National or Nation-wide programme which reviews all deaths of people with a learning disability, aged 4 years and over. There are LeDeR Local Area Contacts in each Local Authority. LeDeR is not a statutory process but is an NHS 'Must Do' and a national priority. It does not replace the SAR process but can run concurrently with a SAR. A LeDeR may trigger a statutory process if multiagency learning needs are identified for the local area. Each Board should have in place appropriate links between the LeDeR and the SAB so as learning to improve adults with care and support needs is shared. Business Managers and the LeDeR ICS Local Area Contact should ensure practical arrangements for running reviews concurrently are taken into consideration at the commencement of reviews, particularly where this involves family involvement and access to patient records.

3.8 The SAR Subgroup will consider any parallel processes when considering a suitable methodology for any SAR.

4. CRITERIA FOR SAFEGUARDING ADULT REVIEW

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

• An adult in its area dies as a result of abuse or neglect, whether known or suspected, *and* there is concern that partner agencies could have worked more effectively to protect the adult.

• If the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

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

• the individual would have been likely to have died but for an intervention.

• the individual suffered permanent harm as a result of abuse or neglect.

• the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

• the individual has sustained a potentially life-threatening injury through abuse or neglect,

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

• A case featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.

• A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.

4.5 Any agency or professional body, together with the coroner, may refer such a case to the MSAB seeking a SAR to establish if there are important lessons for inter-agency work to be learnt from any given case. (For how to make a referral see Appendix 1).

4.6 Specifically, Section 44 of the Care Act 2014 states:

1. "An 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. An 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)."

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

5.1 Any agency, individual or professional may consider that a case meets the criteria for a SAR and request that one be undertaken. It is expected that any request is first considered by the agency or organisation for whom the professional works, and that the most senior manager or their MSAB representative makes any formal referral. (The prospective referrer may find it helpful to discuss the issue with Council's Head of Safeguarding and Professional Standards, or CCG's Director of Quality /Lead Nurse in the first instance). In all cases, it is expected that the criteria in Section 4 is fully considered before making any referral.

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

5.3 The formal referral to the MSAB should be made using the Referral Notice form in Appendix 1 to the Chair of the Subgroup. Details for submission are set out on the form in Appendix 1.

5.4 Upon receipt of a SAR referral the Chair of the Sub-Group will review the information against the criteria and will agree to convene the Sub-Group to consider the merits of the referral, and the appropriate methodology to follow.

5.5 In deciding whether a referral should progress to a SAR, the Subgroup will invite the referrer to the Subgroup meeting to present their completed referral, allowing the Subgroup to clarify matters as required.

5.6 If the issue under consideration is also the subject of a Police investigation or judicial process, then the SAR Subgroup will need to be advised or will seek to identify this before considering the next steps. Equally where an issue triggers a mandatory investigation or review within an organisation (e.g., NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. In all such cases, legal advice may be appropriate to guide the decision making.

6. DECIDING TO UNDERTAKE A SAFEGUARDING ADULT REVIEW

6.1 The Sub-Group remains responsible to the MSAB. The Chair of the MSAB has ultimate responsibility for deciding whether or not to conduct a SAR.

6.2 In deciding if a SAR should be undertaken, the Subgroup will refer to the flow chart on page 11 and the supporting information on SAR methodologies.

6.3 Once a referral is received, considered and the Subgroup agrees that a SAR should be instigated, the Chair of the Subgroup will notify the MSAB Chair of the recommended actions that should then follow, including the proposed or recommended methodology (see Section 7). This decision to proceed (or not) will be made ideally within 14 days but no later than one month. In all situations the notice of the referral and the decisions that follow will be raised at the next SAB and recorded.

6.4 If the recommendation of the Sub-Group is not to proceed to a SAR, the sub-group may consider whether to request an alternative review or a smaller-scale audit of agency involvement. In such cases, arrangements should be made for the agency to share relevant findings with the Sub-Group or other appropriate body. The MSAB Chair will be notified of the referral and subgroup decision.

6.5 If the Chair of MSAB does not agree with the recommendation of the SAR Sub-Group (proceed or not proceed), a meeting should be convened with the Chair of the Sub-Group to try to resolve the issue as a matter of urgency. If necessary, a special meeting of the full MSAB should be convened to make a final decision.

6.6 Whatever the ultimate decision, the referrer should be notified by letter from the Chair of the Sub-Group, within a reasonable time scale. If the SAR is not to proceed, then the letter should outline the reasons for the decision.

6.7 All such decisions and actions, including those that are taken by the Subgroup, or a convened SAR Panel must be based upon the six principles of safeguarding (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability – see Care Act Statutory Guidance and London Multi-Agency Safeguarding Adults Policy and Procedures for more details). Any objections to the decisions made, should be put in writing within 7 days of notification. Consideration will be given as to a whether a review of the referral and decisions reached be carried out by a different independent chair.

6.8 Once a confirmed decision has been made to instigate a SAR, the Care Quality Commission will be notified by the Chair of the Subgroup.

7. SELECTING THE MOST APPROPRIATE METHODOLOGY FOR THE CASE IN QUESTION

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

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

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

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

(C) Clear **Terms of Reference,** setting out what is the focus and scope of the SAR (and where appropriate, what is not within scope); times frame within which the SAR will focus; roles and expectations and outcomes required. (See Appendix 6)

(D) **Early discussions with the adult and their family/carers** to agree to what extent, how they wish to be involved and to manage expectations. This includes access to independent advocacy if required (See Section 10)

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

(F) **A final report and recommendations,** which effectively sets out the specific and wider learning considerations (See Appendix 7)

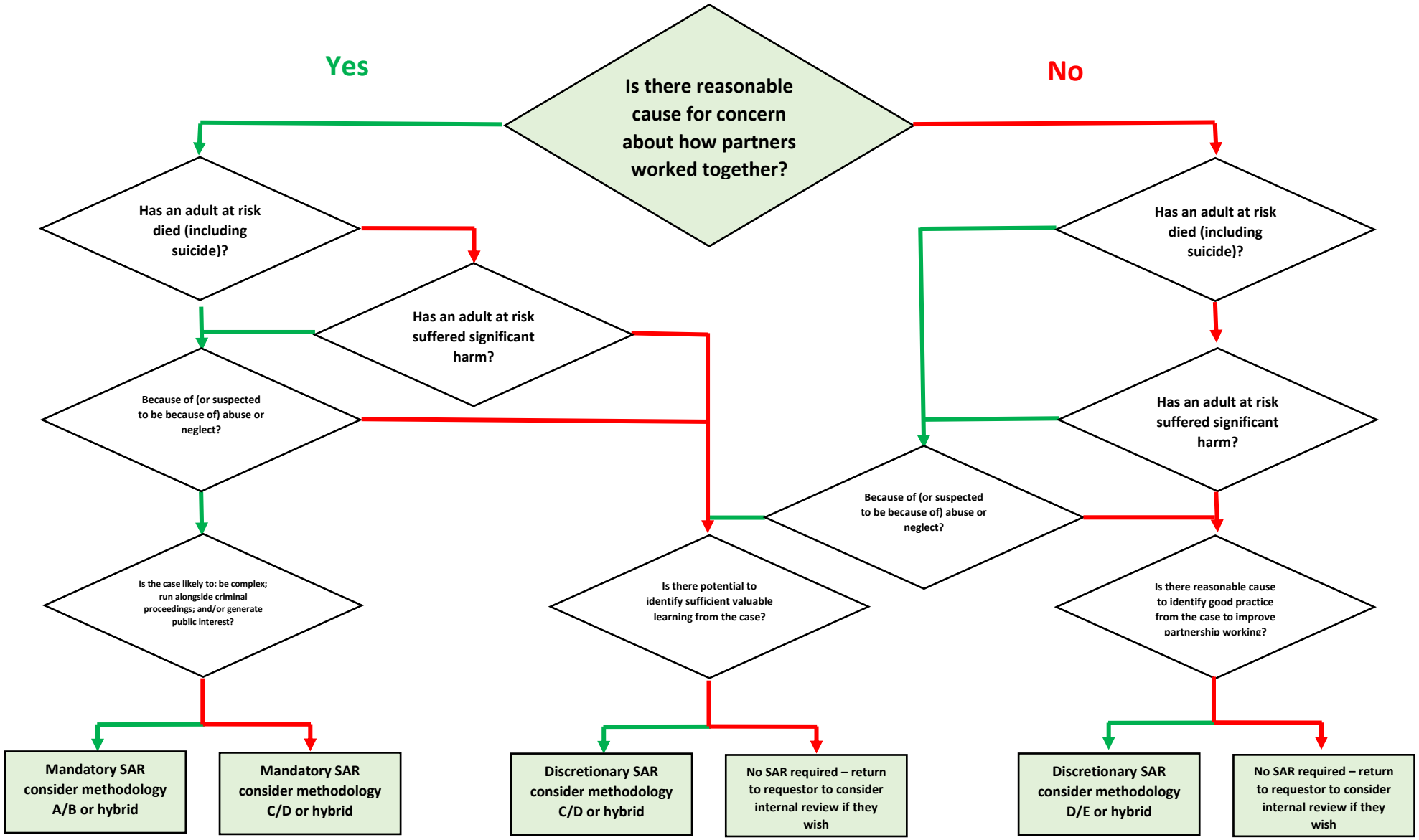
7.2 Whatever methodology is used it must be proportionate to the specific circumstances of the individual case. It should, however, provide the most effective learning mechanism and best enable the involvement of key agencies and staff as well as those who are connected to the person (e.g., family etc.). It must, however, be balanced against the cost, resources and length of time required to conduct the review and the subsequent outcome required.

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

- Is the case complex, involving multiple abuse types and/ or victims?
- Is significant public interest in the review anticipated?
- What level of staff/ family involvement is wanted/ appropriate?
- Are any criminal proceedings ongoing that staff are witnesses in, and could the SAR methodology impact on them?
- Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
- What is the quickest and simplest way to achieve the learning?
- Is a more appreciative approach required to review good practice?
- Are trained lead reviewers available in-house or nationally for the method selected? Are resources available to train or commission a lead reviewer?
- Can value for money be demonstrated?
- Is the right person available to lead the type of preferred methodology?

How the right person to lead the SAR will be identified and agreed.

SAR Methodology Decision Tree: To be updated to reflect discretionary reviews



8. DIFFERENT METHODOLOGY OPTIONS AND CONSIDERATIONS FOR A SAFEGUARDING ADULT REVIEW

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

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

8.3 There are broad considerations prior to initiating a SAR. Some of these may feature in the initial decision making and some will feature in more detail in the actual carrying out of the SAR. These include, but are not limited to:

- The level of independence that is required of people who will be involved in the SAR (and who may be possible Panel Members and who may be involved in writing any reports or developing any agency analysis for the process).
- Level of independence required of the SAR Chair (e.g., representative from another agency, external consultant etc.)
- The broad Terms of Reference for the SAR (see Appendix 6 for a template) including timescales for completion and how learning from the SAR will be disseminated and embedded
- The required output from the SAR.
- Whether an independent author is required, and level of independence.

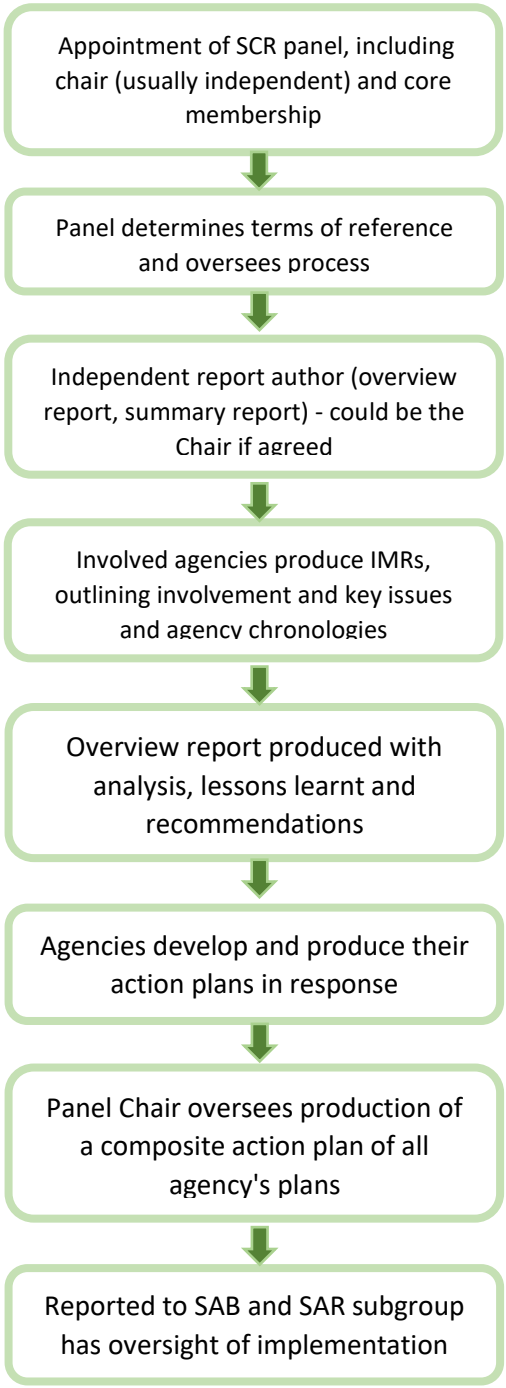
OPTION A: Traditional SCR Approach

Key Features:

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

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

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



OPTION B: Systems Analysis

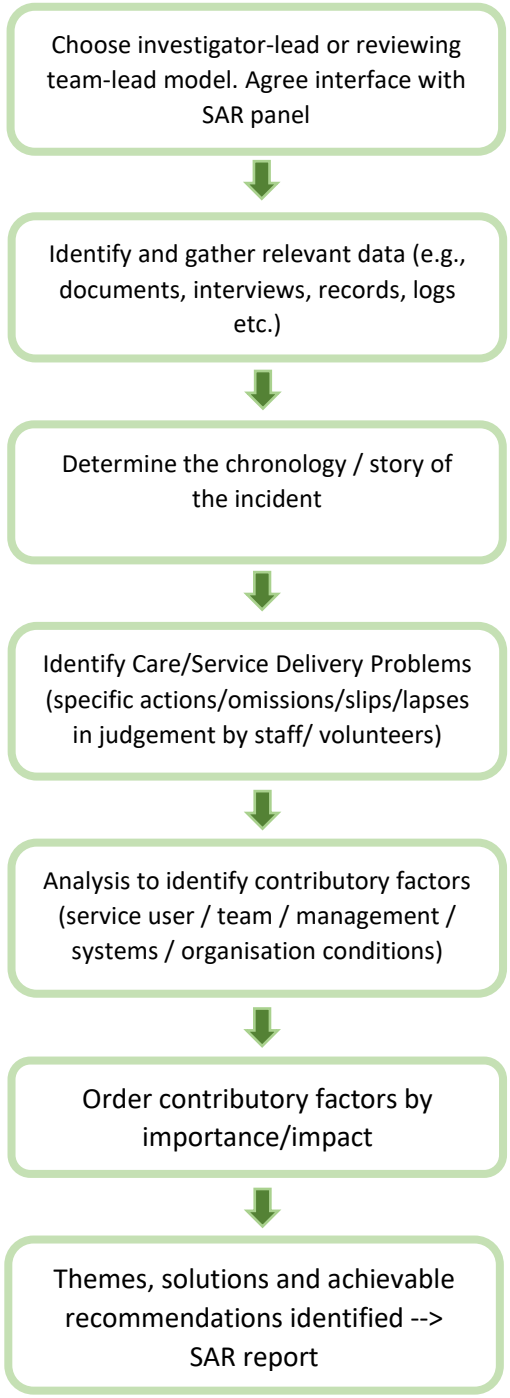
Key Features:

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

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

Available models:

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



OPTION C: Learning Together

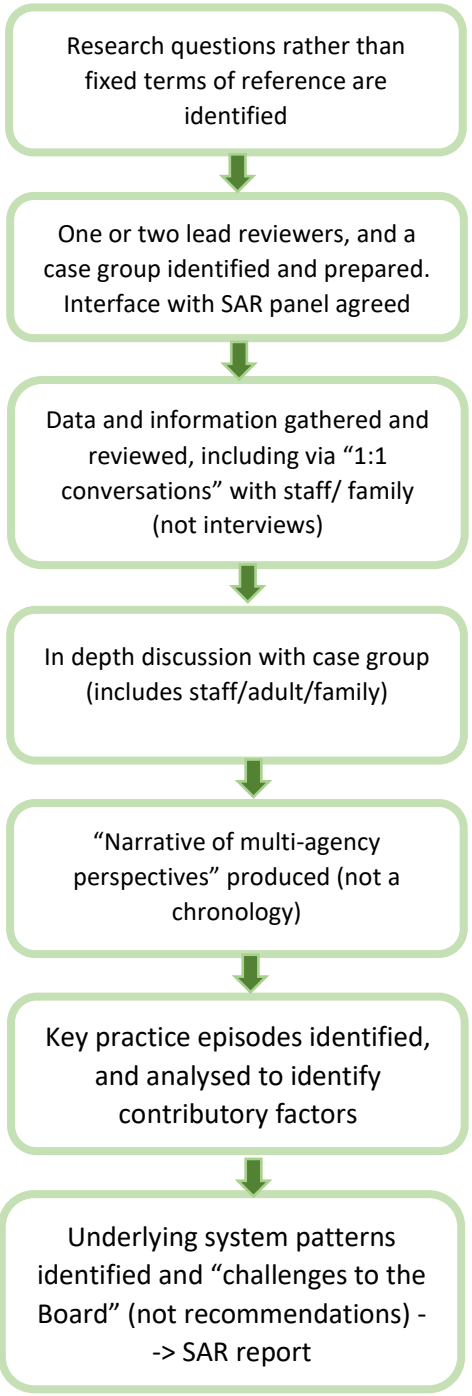
Key Features:

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

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

Available models:

SCIE, Learning Together



OPTION D: Significant Incident Learning Process

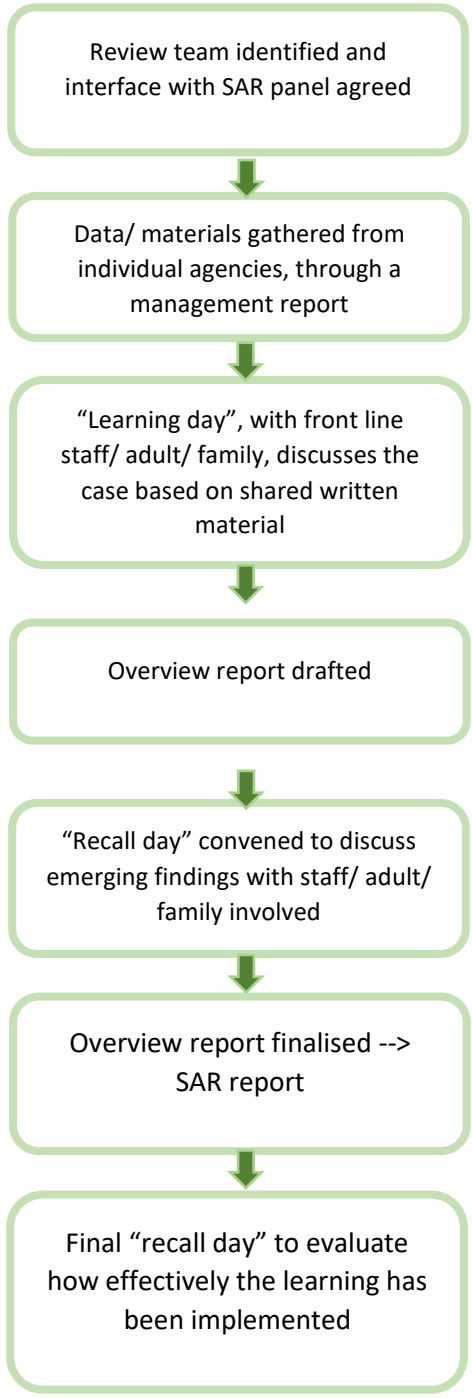
Key Features:

- Review team and learning day led
- Staff/ family involved via learning days
- Single agency management reports
- No chronology
- Multiple learning days over time
- Explores the professionals' view at the time of events, and analyses what happened and why

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

Available models:

Tudor, Significant Incident Learning Process



OPTION E: Significant Event Analysis

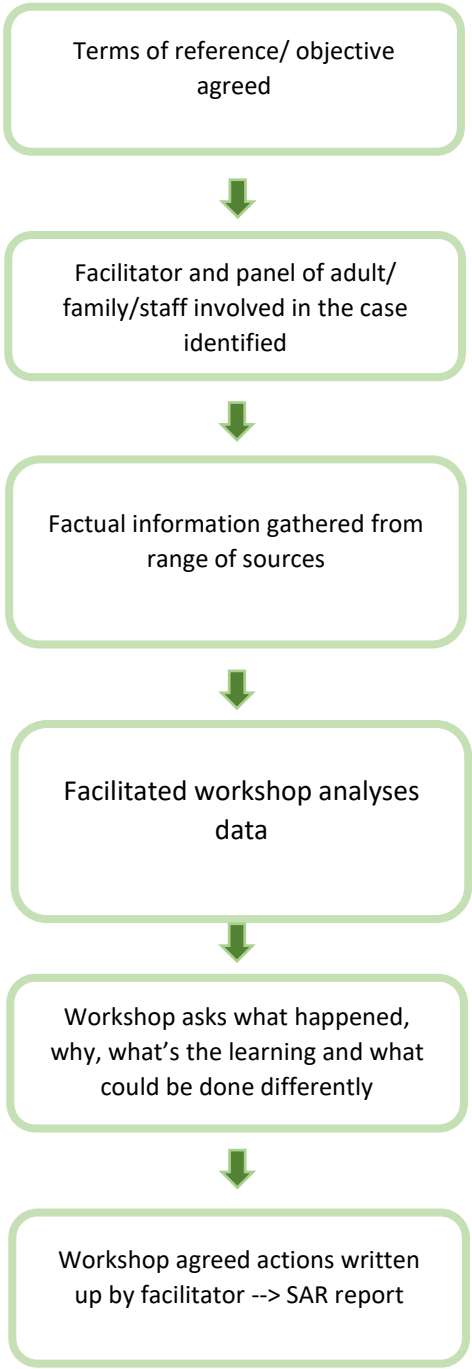
Key Features:

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

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

Available models:

NHS Education for Scotland and NPSA, Significant Event Analysis
Care Quality Commission, Significant Event Analysis
Royal College of General Practitioners, Significant Event Audit



OPTION F: Appreciative Enquiry

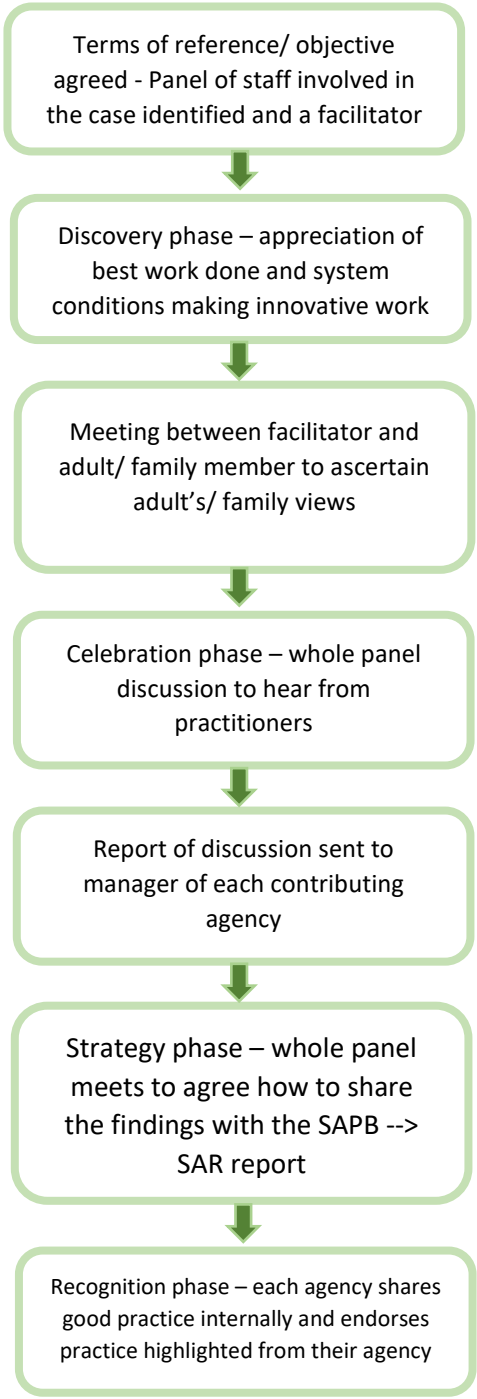
Key Features:

- Panel led, with facilitator
- Staff involved via panel. Adult/ family involved via meeting
- No chronology/ management reports
- Aims to find out what went right and what works in the system, and identify changes to make so this happens more often

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

Available models:

Julie Barnes, A new model for learning from serious case reviews
Newcastle Safeguarding Children's Board, Appreciative Inquiry Champions Group



9. INITIATING AND CONDUCTING A SAFEGUARDING ADULT REVIEW

9.1 As soon as it has been established and agreed **that a SAR should take place** the Subgroup will need to consider which agencies should be involved, especially as some may not be immediately obvious. In doing so the Subgroup will use its best endeavours to identify the agencies that should be approached and the process by which it will do so.

9.2 In instigating the SAR process, the Chair of the Sub-Group, will on behalf of the SAB:

9.2.1 Write to the Senior Accountable Officer[3] of each relevant involved agency (copying in their SAB representative/ Safeguarding Adult lead) advising them that their agency's records relating to the adult at risk in question need to be secured with immediate effect. They will also be asked to nominate a representative for any SAR Panel that is subsequently convened.

9.2.2 Confirm any specific actions required of the agency in preparation for the SAR (depending on which methodology is being followed) such as the need to prepare for any Individual Management Review (IMR) using Letter A (see Appendix 5). The templates for completing the chronology and the analysis components of the Individual Management Review (see Appendix 3) will conveyed to the agency.

9.3 As part of the considerations for commencing a SAR, the Subgroup will take the lead responsibility for identifying and appointing an appropriate Independent Chair of the SAR Panel with sufficient standing and expertise, ensuring there is no conflict of Interest.

9.4 Depending on the methodology being used, the Chair could be a MSAB Member, or an appropriate senior manager from a partner organization who will oversight of the SAR process. If a full SAR methodology with IMRs is being instigated, it is likely the Chair will be specifically appointed for this purpose.

9.5 The Independent Chair, in conjunction with the Subgroup will:

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

- Agreeing how the Independent Chair raises any issues that arise as part of the process and with who

9.6 All agencies represented on the MSAB, must be aware of the criteria for implementing a SAR as set out above. The MSAB members commit to their agency being involved in any SAR if their professional role can add value to the process. Safeguarding arrangements as required under the Care Act do require agencies to co-operate.

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

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

10.2 If the relative(s) to be involved is considered an 'adult at risk', consideration must be given to the support they require in terms of a representative or advocate.

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

10.4 The 'adult at risk' may need a worker and/or advocate supporting them through the process; where relevant, appropriate communication with the worker and/or advocate will need to be considered. This will include informing them of the SAR and, if they are not SAR Panel members, sharing the outcomes in a way they wish for them to be shared.

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

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

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

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

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

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

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

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

12. PROFESSIONAL CONDUCT ISSUES

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

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

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

13. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

13.1 There will always be a final report with recommendations arising from a SAR, irrespective of the methodology used to undertake the review. The complexity and proportionality of the report will be matched the issues in question.

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

13.3 The final report should always be produced as soon as is practical at the conclusion of the SAR process. The SAR panel should receive and agree the draft report before it is presented so that individuals are satisfied the panel's analysis and conclusions have been fully and fairly represented. However, it should be understood the lead person for the SAR is the person that should have final editorial oversight. If there are issues arising that are contentious, and full agreement to the final report is an issue, then the Chair of the SAR Sub-Group should be engaged to enable an appropriate way forward.

13.4 Final reports (including an Executive Summary, recommendations and any agency action plans) will be presented to the SAR Sub-Group ahead of any SAB meeting, to consider the issues and resulting recommendations seeking clarification on any issues as required. Any outstanding issues or resolution will be confirmed. The final agreed report, with a resulting Composite Action (developed by the SAR Subgroup) will then be presented to the next SAB

13.5 A sample report template is provided in Appendix 7.

14. PUBLISHING REPORTS

14.1 The MSAB recognizes collective responsibility, open and transparent governance and the need for evolved learning. However, considerations of reputational risk or national learning arising from the case may affect decisions as to how the report is published. The MSAB will decide to whom the SAR report, in whole or in part should be made available, and the means by which this will be done. This could include publication via the MSAB webpage, which at present is part of the Council's website. Agencies and MSAB members can provide the relevant links as required. This will be kept under review,

14.2 The chair of the MSAB will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with prevailing Information Sharing Agreements, the Data Protection Act, Information Governance arrangement and other legal requirements.

14.3 The Care Act requires the MSAB to publish the findings of any SAR in its annual report, recognising the interests, transparency and disseminating learning but doing so within the legal parameters of confidentiality, setting out how learning will be implemented. Where the MSAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report[4] .

14.4 Any reports to be published must be fully anonymised. However, in doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised nomenclature.

15. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

15.1 The real value of a SAR is to ensure that the relevant lessons, specific or wider learning, are understood, the impact considered, addressed and consolidated into improved working arrangements within and across all services supporting vulnerable adults at risk and that multi-agency safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

15.2 The SAR Sub-Group will be responsible for ensuring the development of a Composite Action Plan (see Appendix 8) to ensure identified report recommendations are fully set out, prior to presentation to the SAB.

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

15.4 In addition to SARs that are conducted by the MSAB, it will be as important to learn from SARs conducted by other SAB areas more generally, but especially where they relate to a Merton person whose services have been commissioned in another local authority area, or where any Merton provider or agency is involved. This is to ensure that the MSAB does everything possible to prevent similar issues occurring in its area.

16. SUPPORTING AND RESOURCING SAFEGUARDING ADULT REVIEWS

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

16.2 The MSAB has to take a lead role in supporting the SAR process, supporting the setting up of the SAR Panel and supporting the SAR Subgroup in ensuring the right resources are made available to respond to this statutory requirement. This could include, but not limited to, budget to hire an independent chair or facilitator, additional

capacity to facilitate all necessary actions, reports and writing of the report and support to relatives or people at the focus of the SAR in terms of advocacy or personal representatives.

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

17. SUMMARY OF GROUP RESPONSIBILITIES

Responsibilities of the Safeguarding Adult Review Panel

17.1 In addition to the more detailed issues set out within this Protocol, the SAR Panel will have specific responsibility for agreed activity and actions.

17.2 The SAR Panel, under the leadership of the Independent Panel Chair, will lead the review of the circumstances and issues surrounding the matter referred for SAR, using whatever methodology has agreed.

17.3 The SAR Panel is made up of a minimum of a nominated Chair, supported by the Safeguarding Board Business Manager (or agreed alternative) representing the SAR Subgroup and a dedicated Board Administrator along with key individuals who have been invited to be involved, depending upon the methodology being used. As a minimum statutory agencies such as the local authority, police and health commissioners (ICB) will be involved.

17.4 The SAR Panel will clearly set agreed terms of reference, clear process and direction for gathering information depending on methodology being used, as well as collate and review information.

17.5 The final product will be an Overview Report, including recommendations, accompanied by an Executive Summary as well as any specific action plans from contributory organisations.

17.6 Throughout this process the SAR Panel will consider communication matters and communication strategy, linking with the SAR Subgroup as required. Where legal opinion or guidance is required, this should be provided by the Council Legal Services, and will be accessed via the linked representative of the Subgroup sitting on the SAR Panel.

17.7 The SAR Panel's work should be completed within 6 months of the initial decision to commission a SAR. Agency improvements should commence as soon as they have been identified (e.g., prior to or during the earlier stages of the Review).

Responsibilities of the Safeguarding Adult Review Sub-Group

17.8 The SAR Subgroup has delegated responsibility from the SAB to have oversight of all SAR activity, policy and process. When a SAR has been commissioned, the SAR Subgroup, under the leadership of the Subgroup Chair (or nominated representative) acts as a liaison to the SAR panel and will arbitrate on any issues or decisions the SAR Panel and Independent Chair identify or raise.

17.9 The Subgroup acts as the intermediary between any SAR Panel and the MSAB, and supports the work of the Panel in whatever way is appropriate either as a collective group or through delegated tasks to assigned members or assigned representatives

17.10 The SAR Subgroup will work with the MSAB and SAR Panel to identify if any conflict of interests are identified and to address (e.g., a SAR Subgroup agency representative may also be required to produce an IMR for the Panel). Mitigating actions will be put in place and monitored so the best possible evidence is collated and review appropriately.

17.11 Throughout the process the subgroup, via the Chair, should monitor the progress of the SAR via updates from the independent Chair/report writer. In the main this will be via the Board Manager.

17.12 The Final Overview Report, Executive Summary and recommendations will be presented to the Sub-Group to enable supportive presentation to the SAB. The Subgroup will ensure that there is a relevant Composite Action Plan, turning recommendations into actions and that this accompanies any documentation to be presented to the MSAB.

17.13 The Sub-Group will inform the MSAB Chair that the review has been concluded and the report is available. Arrangements will be made for the Overview Report to be presented to a MSAB meeting, so it can approval of the Report.

Responsibilities of the MSAB

17.14 Ultimate responsibility for the completion of an agreed SAR, the related recommendations and their implementation remains with the MSAB. They are also required to lead on communication issues and ultimate publishing arrangements. In practice the SAR Subgroup undertakes most of this as the delegated group, but accountability remains with the MSAB.

17.15 The MSAB will formally approve the Overview Report and formally accept the review findings and recommendations as appropriate. Any recommended final revisions should be referred back to the SAR Panel for their action.

17.16 An Executive Summary will be produced to share the learning from the SAR, The MSAB will need to confirm how and if the report is made public, the form of this and any following communication or media management.