



# **Haringey Safeguarding Adults Board**

## **Safeguarding Adults Review Procedure**

**This document sets out how to request and conduct  
Safeguarding Adults Reviews in Haringey  
Under Section 44 of the Care Act 2014**

**3<sup>rd</sup> Edition October 2018**

Date approved by HSAB QA subgroup: September 2018

Date approved by HSAB: October 2018

Date of next review: October 2021

**Contents**

- 1. Introduction..... 3
- 2. The Purpose of Safeguarding Adults Reviews ..... 4
- 3. Criteria for Safeguarding Adults Reviews ..... 4
- 4. Referral of Cases for a Safeguarding Adults Review ..... 5
- 5. Commissioning a Safeguarding Adults Review ..... 8
- 6. Relationship to other reviews ..... 9
- 7. Membership of a Safeguarding Adults Review Panel ..... 9
- 8. Conduct of a Safeguarding Adults Review ..... 10
- 9. Drafting the reports and public summary ..... 10
- 10. Considering the Recommendations..... 11
- 11. Timetable ..... 12
- 12. Sharing the Lessons Learnt ..... 12
- 13. Appendices ..... 12
  - Appendix A: Reviews under the Care Act 2014.....13
  - Appendix B - Safeguarding Adults Review Protocol ..... 14
  - Appendix C: Safeguarding Adults Review Referral Form ..... 15
  - Appendix D – Social Care Institute for Excellence: Safeguarding Adults  
Review Quality Markers checklist..... 18

# Safeguarding Adults Review Procedure

## 1. Introduction

- 1.1 The Care Act 2014 Section 44 requires Safeguarding Adults Boards (SABs) to conduct Safeguarding Adults Reviews (SARs) in specified circumstances.
- 1.2 The Care Act 2014 states “SARs should reflect the six safeguarding principles” these are:
  - 1) **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
  - 2) **Prevention** – It is better to take action before harm occurs.
  - 3) **Proportionality** – The least intrusive response appropriate to the risk presented.
  - 4) **Protection** – Support and representation for those in greatest need.
  - 5) **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
  - 6) **Accountability** – Accountability and transparency in delivering safeguarding.
- 1.3 Haringey Safeguarding Adults Board (SAB) has a duty to carry out a Safeguarding Adults Review (SAR) when an adult at risk in Haringey 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.
- 1.4 Haringey SAB must also arrange a SAR if an adult with care and support needs is still alive but has experienced serious neglect or abuse. The adult who is the subject of the SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.
- 1.5 SABs also have discretion to arrange for a SAR in other situations where they believe there will be value in doing so.
- 1.6 Safeguarding Adults Reviews must not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from individual cases can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases, it may not be possible to complete or to publish a Review until after the Coroner’s Hearing or criminal proceedings have been concluded but this must not prevent early lessons learned from being implemented.
- 1.7 The Care Act 2014 requires SAB member agencies to cooperate with and contribute to the carrying out of a SAR.
- 1.8 The purpose and underpinning principles of SARs, and the broad requirements and guidance for conducting SARs, are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures. This policy and procedure has been adopted by Haringey SAB and provides the overall governance of our SAR approach.
- 1.9 The Care and Support Statutory Guidance, updated in July 2018, Chapter 14, provides specific guidance on SARs (see section 14.162 – 14.173) and this is supported by additional information and guidance provided by the Social Care Institute for Excellence (SCIE) in 2015, including the SARs Library, established in 2018.

- 1.10 This procedure document aims to ensure that there is a consistent approach to the process and practice in undertaking Safeguarding Adults Reviews (SARs).
- 1.11 The Haringey SAB will include in its Annual Report the findings of the reviews arranged by it under this procedure, which have concluded in that year. The SAB will, other than in exceptional circumstances, publish all reviews on its website.

## 2. The Purpose of Safeguarding Adults Reviews

- 2.1 SARs should seek 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 learnt from the case and those lessons applied to future cases to prevent similar harm occurring again.
- 2.2 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, the Health and Care Professions Council, and the General Medical Council.
- 2.3 The purpose of a SAR is not to reinvestigate or apportion blame but to:
- Learn from the way local agencies, staff and volunteers worked together to safeguard adults at risk, both what did and what did not work well;
  - Agree how this learning will be acted on, and what is expected to change as a result;
  - Identify any issues for multi or single agency policies and procedures;
  - Inform and improve local inter-agency practice; and
  - Provide an overview report that brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.
- 2.4 SARs are not disciplinary proceedings and should be conducted in a manner which facilitates learning and appropriate arrangements must be made to support staff involved with the case. If there are issues of performance and/or discipline which needs to be addressed arising from the SAR, then these must be dealt with within each agency's normal procedures.
- 2.5 It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. This procedure is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

## 3. Criteria for Safeguarding Adults Reviews

- 3.1. The SAB must arrange for there to be a review of a case involving an adult in Haringey 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.

### 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).

**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.

The 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).

Each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to:

- (a) identifying the lessons to be learnt from the adult's case, and  
(b) applying those lessons to future cases.

3.2. Haringey 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).

3.3. In deciding whether a SAR should be conducted in cases other than those involving a death, the following questions should be considered. A positive response to several is likely to indicate that a SAR should be conducted:

- Was there **clear evidence** of a risk of significant harm to an adult at risk that was:
  - i. not recognised by agencies or professionals in contact with the adult or perpetrator; *OR*
  - ii. not shared with others; *OR*
  - iii. not acted upon appropriately?
- Was the adult abused/neglected in an institutional setting?
- Was the adult abused/neglected while being supported by the local authority or a NHS Trust?
- Does one or more agency or professional consider that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding adult protocols, which go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the SAB may need to change its local policy, protocols or practice guidance, or that protocols and guidance are not adequately being disseminated, understood or acted upon?

#### 4. Referral of Cases for a Safeguarding Adults Review

- 4.1. Any agency representative or professional must refer a case believed to meet the threshold of the criteria contained in paragraphs 3.1, by completing the SAR referral form. Staff may wish to consult their agency safeguarding lead.
- 4.2. Referrals must be made directly to the Haringey Safeguarding Adults Board using the template at Appendix C.
- 4.3. Following receipt of a SAR referral form, the Board Co-ordinator will advise the Independent SAB Chair of the information received and advise that a meeting of the SAR Subgroup is being arranged. The Board Co-ordinator will contact relevant agencies, involved in the case, to advise them of the complete, to request they lock down the records if appropriate and to request they complete a summary of involvement.
- 4.4. The SAR Subgroup will consider the referral and summary of agency involvement responses and discuss the issues in the case.
- 4.5. Referrals will be considered by the SAB SAR sub-group which is chaired by the Independent SAB Chair and convened periodically through the year and when required to consider a SAR.
- 4.6. The SAR Subgroup is chaired by the SAB Chair and must include representatives from:
  - Adult Social Services
  - Haringey Clinical Commissioning Group
  - Metropolitan Police Service (Haringey Division)
- 4.7. The SAR sub-group will consider whether or not the request meets the statutory criteria for a SAR.
- 4.8. Based on this information it will agree one of the following options, detailing the rationale for this decision:
  - Safeguarding Adults Review
  - Single Agency Review (e.g. Serious Incident)
  - No Further Action (SAR criteria not met)
  - Other Multi-Agency review (LeDeR, DHR)
- 4.9. It may also be necessary to consider whether the case meets the criteria for other multi-agency reviews. For example:
  - Serious Case Review(SCR)
  - Domestic Homicide Review (DHR)
  - MAPP Serious Case Review
  - Mental Health Homicide Review (MHHR)
  - (as above) Serious Incident (SI)Please see Appendix A: Reviews under the Care Act 2014 to determine process for undertaking SARs<sup>1</sup>.
- 4.10. When a decision to commission a SAR is taken, the Chair will notify all agencies involved to ensure that relevant records are secure. They will then follow the process under paragraph 5 below – Commissioning a Safeguarding Adults Review.

---

<sup>1</sup> Courtesy of Leicester Safeguarding Adults Board

The Specialist Crime Review Group will need to be notified at [SeriousCaseReviews@met.police.uk](mailto:SeriousCaseReviews@met.police.uk) when a SAR is commissioned where there is a death including suicide.<sup>2</sup>

- 4.11. When **the Board decides not to hold a SAR**, the Chair of the Panel will write to the person requesting the review and relevant statutory director(s) explaining the reasons for refusing the request. If the initiator wants to appeal against a decision not to carry out a SAR it should be put in writing to the Independent Chair of the SAB, who will discuss and review (if necessary) the decision with the requestor and the panel of Board members who decided on the initial request.
- 4.12. **Where the request for a SAR does not** meet the criteria and the Board has chosen not to use its discretion to commission one, the Board can recommend that an individual agency review an incident. The agency should be asked to use its own internal investigation procedures to do this.
- 4.13. The requesting agency can choose to take no further action or to undertake an internal review using an appropriate methodology (as set out in the London Multi-Agency Safeguarding Adults Policy and Procedures). All relevant organisations must continue to implement any actions in the protection plan from any original Section 42 safeguarding enquiry.
- 4.14. The complaints procedure of the local authority or other relevant partner organisation, depending on the nature of the complaint of the case in question should be followed should a complaint be made.
- 4.15. Any such reviews should be completed promptly and the findings, facts, learning points and actions shared with the Board who will respond to any issues requiring their consideration.

---

<sup>2</sup> Notification from SAB Chairs Network – August 2016

## 5. Commissioning a Safeguarding Adults Review

- 5.1 Haringey SAB will be the only body, which commissions a SAR relating to the abuse and/or neglect of an adult at risk in Haringey. The SAB SAR sub-group will oversee:
- Drafting the terms of reference for the SAR;
  - Appointing the SAR Panel, Chair and the independent review author. The Chair should be independent of the review. The author will be a fully independent individual with the required set of skills and experience to carry out this work;
  - The Panel should include key statutory leads and agencies involved in the review, represented by senior officers that have no connection to the case under review;
  - Receiving regular reports from the Panel Chair regarding progress of the review;
  - Making sure that resources are available for the SAR;
  - Setting timescales within which the review is completed – this is expected to be **within** six months;
  - Securing any legal advice required, including Data Protection, Freedom of Information and Human Rights legislation;
  - Managing the interface between the review and any other investigations or reviews of the same case that may be taking place;
  - Agreeing arrangements for administrative and professional support;
  - Ensure that the SAR is proportionate to case concerned; and
  - Agreeing publication arrangements.
- 5.2 The SAB Chair will notify the Care Quality Commission, Police and Coroner’s office that a SAR is taking place.
- 5.3 Reflecting the principles of openness, transparency and candour, the SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible victims of abuse and their families. In accordance with the Care Act 2014, where an adult has difficulty in participating, this should involve representation and support from an independent advocate.
- 5.4 The SAR Panel may appoint a “liaison person” who will have specific responsibility to keep the Adult at risk, their family or friends, informed of developments relating to the SAR. Where relevant, this person will need to keep in close contact with the police family liaison officer to make sure that communication is consistent.
- 5.5 The SAR Panel will make recommendations to the SAR sub-group about publication and media and communications strategy.
- 5.6 If a Serious Case Review (SCR) will also be required to be undertaken by Children’s Services or a Domestic Homicide Review (DHR) by community safety services, the Chair of the SAR will be responsible for making contact with the Chairs of any SCR or DHR to agree how the reviews can be managed to maximise learning from the case.
- 5.7 The Social Care Institute for Excellence (SCIE) have published SAR Quality Markers (June 2018) as a tool to support people involved in commissioning, conducting and quality assuring SARs. The Quality Markers are based on established principles of effective reviews/investigation as well as experience, expertise and ethical considerations – see Quality Markers in Appendix D.



## **6. Relationship to other reviews**

- 6.1 In setting up a SAR the SAB should also consider how the process could dovetail with any other relevant investigations that are running parallel, such as a child Serious Case Review (SCR) or Domestic Homicide Review (DHR), a criminal investigation or an inquest.
- 6.2 It may be helpful when running a SAR and DHR or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.
- 6.3 It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

## **7. Membership of a Safeguarding Adults Review Panel**

- 7.1 Individual members of the Panel will come from the main partnership agencies and have appropriate seniority and experience with regard to the case under review. The chair of the Adult Safeguarding Board will contact partner agencies for nominations to the SAR Panel.
- 7.2 The Panel will consider how the adult at risk and/or their family and/or appropriate representative, can be involved in the process and kept informed on its progress. The views of the adult at risk and/or their representative must be sought and reflected in discussions, in the final reports and its recommendations.
- 7.3 In looking at the Panel membership, consideration should be made to include an "Expert by Experience". This would be subject to relevant satisfactory checks and normal requirements on confidentiality being followed.
- 7.4 Resources are needed for undertaking and supporting a SAR. The statutory partners on the Haringey SAB will provide resources, in cash or kind, on a shared basis to ensure that the relevant costs for each SAR can be met. These will vary according to the methodology selected – e.g. a SAR requiring the services of consultants as independent chair and independent author will be more costly.
- 7.5 The statutory partners on the Haringey SAB will also ensure that the SAR chair and panel receive adequate administrative support, and will take a decision on how and from whom this will be provided.
- 7.6 All partners will commit internal resources to the production of evidence for a SAR (e.g. an IMR or interviews/conversations with relevant staff) as requested by the SAR panel.
- 7.7 The SAB Manager will maintain an annual overview of SAR related costs for the SAB, for consideration each year as part of the annual report and to aid annual budgeting by partner organisations.

## **8. Conduct of a Safeguarding Adults Review**

8.1 In each SAR, the Panel will keep in mind the experience, views and preferences of the adult at risk, and look at how these were sought and taken into account by the professionals involved.

8.2 The SAR Panel will:

- Detail terms of reference and outline timescale;
- Agree the level and category of SAR required;
- Establish what evidence is required from each agency or person, and whether this will be collected by investigation or individual management reviews or any other way;
- Request further information from agencies as required;
- Identify relevant policy, practice or procedures, nationally and locally, that may be relevant to the conduct of the review;
- Consider the facts and circumstances of the case and the evidence received;
- Cross reference all agency management reports and reports commissioned from other sources;
- Consider how the SAR will co-operate with any related SCR or DHR;
- Consider relevant professional and practice standards and guidance;
- Take into account the nature and extent of legal advice required, in particular – Data Protection, Freedom of Information, and the Human Rights Act;
- Analyse the evidence to understand why the incident took place. In particular, the Panel will look for any wider systemic issues as well as individual practice issues;
- Identify any areas of effective practice and areas for improvement;
- Examine and identify relevant action points;
- Agree the key points to be included in reports and action plans; and
- Agree the final version of the Review Report and Public summary Report.

8.3 If, during the review, further information or issues emerge that require notification to a statutory body, such as CQC, DH, DfE, Health and Care Professional Council, the Nursing and Midwifery Council, Home Office, General Medical Council, Health and Safety Executive regarding significant omissions by individuals or organisations, this should be reported to the Chair of the Adult Safeguarding Board straight away and they will agree how to proceed and who will make the notification. They will also make the decision about whether the SAR needs to be suspended during such a notification.

## **9. Drafting the reports and public summary**

9.1 The Chair and SAR Panel members are responsible for ensuring the Review Report and Public Summary are drafted and delivered within timescales, and are consistent with the terms of reference. The Report should bring together all the relevant information with an analysis of events, and should include recommendations, where appropriate. The report should cover:

- 1) An account of events and factual findings with a terms developed from individual management reviews and chronologies<sup>1</sup> already submitted;
- 2) Any matters of concern affecting the safety and wellbeing of adults at risk in Haringey;
- 3) Any general public health, safety or wellbeing issues arising from the death of an adult at risk;
- 4) Any need to review policy, practice or procedures;
- 5) Dissemination to other local authorities;

- 6) Identification and integration of learning points from published Safeguarding Adults Reviews, from other areas of research and best practice guidance, including where appropriate mental capacity; and
- 7) Information on references and sources used to prepare the report.

- 9.2 When the report is considered to meet the requirements, the SAR Panel will:
- Send a draft of the report to contributing agencies, inviting comments on factual accuracy;
  - Invite contributing agencies to confirm they are satisfied that their information is fully and fairly represented in both reports; and
  - Invite agencies to confirm that the draft recommendations, as they apply to their agency or more generally, are clear.

It is important to note that agencies are not being asked whether they agree with the report or its findings. The focus is on ensuring the report is factually accurate, understood and recommendations are clear. Agencies have **10 working days** to respond.

- 9.3 The Panel will consider all comments and agree the final version of both the Review Report and Public Summary to be submitted to the Adults Safeguarding Board.

## 10. Considering the Recommendations

- 10.1 Once the SAR Panel have agreed the Review Report and the Public Summary, Haringey SAB will meet **within 2 weeks** to consider it. They will check:
- The Review report is factually accurate and reflects a fair and balanced representation of events;
  - The Public Summary report is endorsed and can be made public;
  - The content is anonymised sufficiently to protect the confidentiality of the contributors, and the adult at risk and family members or others; and
  - Care is taken to make sure that sensitive information is protected and confidential.
- 10.2 Once the Board has endorsed the reports, the SAR Panel will identify the key areas of action, timescales and the lead agency for each action, with a requirement that the relevant agency prepare an action plan for consideration at the next SAB meeting. The SAB will receive reports on progress until all the action points are completed. Where the SAB decides not to implement any of the recommendations or actions, it must state the reason(s) in the annual report.
- 10.3 The SAB Chair will ensure both reports and the action plans are sent to individual agencies, the Care Quality Commission and any other relevant parties.
- 10.4 The adult at risk, their representative, family and friends will be kept informed of progress and of arrangements for publication of the Public Summary.
- 10.5 The SAR sub-group will be responsible for ensuring lessons learned from the review are disseminated for agencies to incorporate into policy and procedure and will maintain oversight of the actions arising.

## **11. Timetable**

- 11.1 The timescale for completion from the decision to conduct a SAR to signing off the final report is **6 months**.
- 11.2 If a longer period is needed, this should be proposed and agreed with the SAB Chair.
- 11.3 In some cases, it is not possible to complete or publish until after Coroner's or criminal proceedings have been concluded. If this is the case, every effort should be made to (i) capture the points from the case about improvements needed and (ii) take corrective action.

## **12. Sharing the Lessons Learnt**

- 12.1 The fundamental purpose of undertaking a review of any description is to identify lessons to be learnt to improve learning and develop practice across multi-agencies to safeguard other adults and children at risk of harm and abuse.
- 12.3 In some cases, it is not possible to complete or publish until after Coroner's or criminal proceedings have been concluded. If this is the case, every effort should be made to (i) capture the points from the case about improvements needed and (ii) take corrective action.

## **13. Appendices**

- Appendix A: Review under the Care Act 2014
- Appendix B: Safeguarding Adults Review Protocol
- Appendix C: Safeguarding Adults Review Referral Form
- Appendix D: Social Care Institute for Excellence: Safeguarding Adult Review Quality Markers checklist

## Appendix A: Reviews under the Care Act 2014

HSAB must determine locally the process for undertaking SARs. No one model is prescribed

### Serious Case Review Model

- This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice. Paper based and does not always ask 'why?'.

### Action Learning Approach

- This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

### Peer Review Approach

- A peer review approach encompasses a review by one or more people who know the area of business. Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

### Thematic Review

- A thematic review can be undertaken when themes are identified from previous SAR's, referrals that did not meet the criteria for SAR's or other types of review or investigation. A thematic review considers an individual case as a starting point, but looks at issues raised generally, rather than the details specific to the case.

### Other Review Model

- Above are 4 methodology options for conducting Safeguarding Adults Reviews, from which Haringey Safeguarding Adults Board can decide upon the most appropriate in each case. It is not intended to be a definitive list, but is designed to provide a number of options which may be considered. No one model is prescribed and alternative review models may be used.

## Appendix B - Safeguarding Adults Review Protocol

Any individual, agency or professional can request a SAR. This should be made in writing to the Chair of the Safeguarding Adults Board using this form. Any such request should be sent to the Strategic Lead – Governance and Improvement Service:

The Independent Chair  
Haringey Safeguarding Adults Board  
c/o Helen Constantine, Strategic Lead – Governance & Improvement Service  
London Borough of Haringey Council  
River Park House – 2<sup>nd</sup> Floor  
255 High Road  
Wood Green  
London N22 8HQ

### Safeguarding Adults Review (SAR) background information

The purpose of a SAR is to:

- Learn from the way local agencies, staff and volunteers worked together to safeguard adults at risk , both what did and what did not work well;
- Agree how this learning will be acted on , and what is expected to change as a result;
- Identify any issues for multi or single agency policies and procedures; and
- Publish a summary report, which is available to the public.

The desired outcome of a SAR is that adults are better safeguarded from significant harm through improved inter-agency working.

The purpose of a SAR is not an enquiry into how a death or serious incident happened. Neither is the purpose to find someone to “blame”. Such matters will be dealt with by the Coroner’s or criminal courts, or other bodies.

If there are issues of performance and/or discipline to be addressed arising from the SAR, then these will be dealt with within each agency’s normal procedures.

All agencies or individuals making a request for consideration will be expected to comply with the council’s confidentiality policy.

## Appendix C: Safeguarding Adults Review Referral Form

<b>1. Your details</b>	
Name:	
Surname:	
Job Title:	
Organisation:	
Address:	
E-mail:	
Phone:	
Date Form Completed:	
<b>2. Please highlight the reason for raising this request from the following list of reasons: (tick where appropriate)</b>	
An adult at risk with care and support needs dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death	
An adult has sustained a potentially life threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect	
Where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk	
Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex , on a larger scale and may require more time	
Where circumstances give rise to serious public concern or adverse media interest in relation to the safeguarding of an adult (s) at risk who has care and support needs	

Appendix C: Safeguarding Adults Review Referral Form

<b>3. Adult's details</b>	
Last Name/s:	
Forename/s:	
Other Names Used:	
Date of Birth if known:	
Age if known	
Gender:	
Home Address:	
Ethnicity:	
<b>4. Circumstances leading to request:</b>	
<p>Please detail the circumstances leading to this Safeguarding Adults Review Request; giving as much factual information as possible to enable a decision for further enquiry to be made</p>	
Have you discussed this with your line manager?	
If no; please give reasons as to why:	



## Appendix C: Safeguarding Adults Review Referral Form

5. Your Manager Details	
Name:	
Surname:	
Job Title:	
Organisation:	
Address:	
E-mail:	
Phone:	
<b>6. Where to send this form:</b>  The Independent Chair Haringey Safeguarding Adults Board c/o Helen Constantine, Strategic Lead – Governance & Improvement Service <b>London Borough of Haringey</b> 2nd Floor, River Park House 255 High Road Wood Green London N22 8HQ	

**Appendix D – Social Care Institute for Excellence: Safeguarding Adults Review Quality Markers checklist<sup>3</sup>**

**Supporting dialogue about the principles of good practice**

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 predominantly on established principles of effective reviews / investigation as well as experience, expertise, 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.

The SAR Quality Markers are based on the Serious Case Review Quality Markers developed for learning from children’s safeguarding cases<sup>1</sup> and adapted for adult safeguarding policy and practice.

**How they help**

The SAR Quality Markers are intended to support commissioners and lead reviewers to commission and conduct high quality reviews. They capture principles of good practice and pose questions to help commissioners and reviewers consider how they might best achieve them. SARs are a complex field of activity where simple rules rarely apply, so judgement is often needed. The Quality Markers are therefore designed to stimulate discussion and support informed judgements. They are not a ‘how to’ handbook because there are a variety of ways in which they can be achieved. The quality markers do not presume or promote any particular model or approach for how to achieve them. They support variety, innovation and proportionality in approaches to case reviews.

**How they can be used**

The SAR Quality Markers can be used in a number of different ways and at different times during a single SAR.

<b>When</b>	<b>Which Quality Markers</b>	<b>For what purpose</b>
At the beginning	All	To create clarity and transparency of what is being commissioned
At the beginning	All	To support practical planning and preparation
Progressively over the course of the review	individual markers as appropriate	To manage and quality assure the process
At the end	All	To structure reflection retrospectively on the review and identify improvements for future SARs

The markers should not be treated as a process map because while the three clusters in which they are structured are broadly sequential, the components within them are not.

---

<sup>3</sup> First published in Great Britain in June 2018 by the Social Care Institute for Excellence © SCIE & RiPFA 2018 (Written by Sheila Fish)

## This document

In the full reference document (forthcoming), each Quality Marker is presented using the following structure:

1. **Quality statement** – a summary description of the Quality Marker
2. **Rationale** – further explanation of the marker and why it is important and necessary
3. **How might you know if you are meeting this QM?** – questions to consider for self-assessment
4. **Knowledge base** – any research or practice evidence underpinning to the marker
5. **Equality & diversity** – any specific equality and diversity issues that are important to consider
6. **Link to statutory guidance & inspection criteria** – any relevant regulations, statutory guidance and national minimum standards
7. **Tackling some common obstacles** – These have been identified by the Lead Reviewers and LSCBs during the LIPP project and can be added to over time.

This document presents a ‘check list’ version’ presenting (1) and (3) from the structure above. The Quality Statement is followed by a list of questions to help people consider how they will know if they are on track to meet the marker. The questions have been broken down to reflect different roles and functions.

## Roles and functions

The SAR process and roles are arranged in a variety of different ways, and in different locations. In order to present the Quality Markers in a way that does not preference some arrangements over others, we have attempted to distinguish functions. The table below distinguishes seven different functions related to SARs. We give an indication of the possible role with responsibilities for that function, but there will be other ways that the functions are accomplished.

This breakdown of functions is used in the Quality Markers checklist version that follows. The checklist version contains the quality statement for each marker, and a set of questions to help people know if they are meeting the Quality Marker. We have differentiated the questions per function, and colour coded them accordingly. The aim is to allow people in different roles to readily identify the questions relevant to them.

SAR roles and functions		
No.	Generic SAR function	Possible role
1	Who is ultimately accountable? Including <input type="checkbox"/> decision to commission a SAR, <input type="checkbox"/> sign-off of the SAR <input type="checkbox"/> providing transparency and accountability via the SAB response and annual report <input type="checkbox"/> seeking assurance of effective responses by agencies and/or Board	SAB Chair
2	Who has delegated responsibility for managing the SAR? Including <input type="checkbox"/> initial information gathering, <input type="checkbox"/> recommendation to proceed or not, <input type="checkbox"/> scoping the review, <input type="checkbox"/> identifying and commissioning reviewers, <input type="checkbox"/> agreeing and publishing the Terms of Reference <input type="checkbox"/> agreeing the methodology / model to be used <input type="checkbox"/> providing quality assurance and challenge	SAB SAR sub-group

3	Who provides practical day-to-day support for the review? Including: <input type="checkbox"/> providing administrative support, <input type="checkbox"/> project management support, <input type="checkbox"/> means of access to data, <input type="checkbox"/> links with staff, <input type="checkbox"/> liaison with the Chair	SAB Business manager or Adult Safeguarding Lead
4	Who conducts the review and provides independent leadership? This may be the same or different roles depending on whether Panel and Panel Chair is used <input type="checkbox"/> providing independent challenge <input type="checkbox"/> ensuring individuals and families are included <input type="checkbox"/> ensuring the review is informed through engagement with front line practitioners and managers <input type="checkbox"/> ensuring an accessible report is produced <input type="checkbox"/> ensuring reviews are conducted in a timely manner.	Reviewer(s) Independent Panel Chair
6	Who does follow-up to a review? Including: <input type="checkbox"/> decide on publication <input type="checkbox"/> deciding/leading on immediate action in response to findings <input type="checkbox"/> providing evidence of responses	SAB Board members and/or SAB SAR sub-group
7	Who monitors the longer-term sustainability of changes and evaluates what difference, if any, has been made?	SAB QA sub-group

<b>Overview (links to be added) Setting up the Review</b>		
1	Referral	The case is referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner
2	Decision making- what kind of SAR, if any	Factors related to the case AND the local context inform decision-making about whether a SAR is needed and initial thinking about its size/scope.
3	Informing the person, their family or other important network	The person, relevant family members, and any other important personal network are told what the Safeguarding Adult Review is for, how it will work and the parameters, how they can be involved, and are treated with respect.
4	Clarity of purpose	The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory process, with the purpose of organizational learning and improvement, and acknowledges any factors that complicate this goal
5	Commissioning	Decisions about the precise form and focus of the SAR to be commissioned take into account a range of case and contextual factors in order to make them proportionate to the potential for learning and improvement. Decisions are made with input from the SAB Chair and members and in conjunction with the reviewers.
<b>Running the Review</b>		

6	Governance	The Safeguarding Adult Review achieves the requirement for independence AND ownership of the findings by the Safeguarding Adults Board and member agencies
7	Management of the process	The Safeguarding Adult Review (SAR) is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources.
8	Parallel processes	Where there are parallel processes the SAR is managed to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.
9	Assembling information	The Safeguarding Adult Review (SAR) gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors.
10	Practitioners Involvement	The Safeguarding Adult Review (SAR) enables practitioners and managers to have a constructive experience of taking part in the review.
11	Involvement of the person and relevant family members and network	The Safeguarding Adult Review (SAR) is informed by the person and relevant family and network members' knowledge and experiences regarding the period under review. They are involved in aspects of the SAR as determined at the outset of the review.
12	Analysis	The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on the routine challenges and constraints to practitioner efforts to safeguard adults.
<b>Outputs, Outcomes and Impact from the review</b>		
13	The Report	The report identifies clearly and succinctly the analysis and findings of the Safeguarding Adult Review (SAR), while keeping details of the person to a minimum. Findings reflect the causal factors and systems learning the analysis has evidenced.
14	Improvement Action	The Board enables robust, informed discussion and agreement by agencies of what action should be taken in response to the Safeguarding Adult Review (SAR) report.
15	Board Written Response	
16	Publication	
17	Implementation and Evaluation	

## Setting up the Review

### Quality Marker 1: Referral Quality statement:

**The case is referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner**

Those with delegated responsibility for managing SARs

- Does the referral state explicitly which of the statutory criteria the case has met
- AND/OR how the case features practice issues to be proactively reviewed before abuse or neglect has occurred, in order to pre-emptively tackle them
- AND/OR specify clearly any other reason why a SAR is needed?
- Does the information provided evidence the rationale given for why the case is being referred?
- Are explanations provided for any delays in the referral?

**Quality Marker 2: Decision-making- what kind of SAR, if any Quality statement: Factors related to the case AND the local context inform decision-making about whether a SAR is needed and initial thinking about its size and scope.**

Those ultimately accountable

- Is the rationale for the decision clear and defensible, paying close attention to the Care Act 2014 and Making Safeguarding Personal principles?
- Have SAB member agencies had the opportunity to contribute to decision-making process?
- Are explanations provided for any delays in decision-making?
- Is there transparency for SAB members on the decision-making process and outcomes?
- Has independent challenge to decision-making been considered?

Those with delegated responsibility

- Has meaningful multi-agency discussion informed the recommendation to the Chair?
- Has there been appropriate challenge about how an adult with care and support needs is defined?
- Have discussions about the abuse and neglect suffered by the person, included self-neglect?
- Have discussions about any cause for concern about the quality of safeguarding practice, overtly referenced the principles of Making Safeguarding Personal?
- Have discussions about any cause for concern about working together to safeguard, included consideration of all parts of the system -provider and commissioner, direct practice and oversight?
- Has available data from existing audits and reviews been used to identify outstanding learning needs locally, as well as what is already known and does not need to be re-learned?
- Have the benefits of proactively learning from practice issues in the case, been considered in tandem with identifying whether any of the statutory criteria have been met?
- Has the recommendation about whether a SAR is needed given an indication of the appropriate size/scope given the case and context?
- Are you clear whether the s42 is completed (where relevant)?
- Have other review pathways been considered and discounted, e.g. DHR?
- Have other parallel processes been identified?

Those providing practical support

- Have all key agencies provided information about their involvement?
- Have neighbouring SABs been asked for information, if the person lived outside the SAB area?
- Has single and multi-agency intelligence from other quality assurance and feedback sources, that is relevant to practice in this case, been gathered, e.g. audits/benchmarking, complaints and previous SARs?

**Quality Marker 3: Informing the person, their family or other important network**  
**Quality statement: The person, relevant family members, friends and network are told what the Safeguarding Adult Review is for, how it will work and the parameters, and are treated with respect.**

Those with ultimate accountability

- Have you noted or praised prompt, clear, accessible, compassionate and respectful correspondence with the person and relevant family or network?
- Is there overt encouragement and support for honest communication to address legitimate questions posed by the person, relevant family members, or other important network?

Those providing practical support

- Has the person, relevant family members, friends and network of the SAR been informed at the earliest stage possible?
- Have the purpose, process and parameters of the SAR been communicated in the most appropriate setting or method to ensure that these can be understood and convey respect to those involved?
- Are opportunities being offered to discuss any queries or clarifications about the SAR purpose, and do they give them a realistic chance of doing so?

**Quality Marker 4: Clarity of purpose**  
**Quality statement: The Safeguarding Adult Board (SAB) is clear and transparent, from the outset, that the Safeguarding Adult Review (SAR) is a statutory process, with the purpose of organizational learning and improvement, and acknowledges any factors that complicate this goal**

Those with ultimate accountability

- Have you demonstrated strong overt leadership about the purpose of the SAR being learning and organisational improvement?
- Have you demonstrated clear expectations that people use the escalation pathway to you, if there is any non-engagement by providers, commissioners or other agencies involved in the SAR?
- Have any complicating factors been honestly acknowledged?
- While the SAR is not designed to apportion blame, it can provide information that feeds into individual or corporate discipline processes, or clarify the grounds for needing to initiate them. As a result, claims that the purpose of the SAR is learning can ring hollow for those involved.
- Has consultation with legal departments been sought if appropriate?

Those with delegated responsibility

- Have you communicated with all the necessary parties (SAB members, involved agency/provider/commissioner leaders, as well as practitioners), a positive message about the purpose of the SAR being learning and improvement of social and organisational conditions to
  - enhance partnership working,

- improve outcomes for adults and families, and
- prevent similar abuse and neglect in the future?
- Is what you are saying underpinned by an agreed organisational accident or incident causation model to aid clarity and provide suitable vocabulary?
- Has meaningful multi-agency discussion allowed for all potential tensions and contradictions to be recognised and managed as best as possible?

Those providing practical support

- Is all standard correspondence clear, that when the SAB decides to arrange a SAR, it is a statutory process both when the case meets the statutory criteria for a SAR, and when the SAB has made the decision to use its power to arrange a SAR for other reasons?

**Quality Marker 5: Commissioning Quality statement: Decisions about the precise form and focus of the SAR to be commissioned take into account a range of case and contextual factors in order to make the SAR proportionate to the potential for learning and improvement. Decisions are made with input from the SAB Chair and members and in conjunction with the reviewers.**

Those with ultimate accountability

- Has the right range of information been assessed, and the necessary expertise been brought to bear in deciding the precise form and focus of the SAR?
- Is the form and focus of the SAR best suited to maximising learning and improvement to the benefit of adults and their families?
- Does the judgement make meaningful reference to the principles of Making Safeguarding Personal and the six core safeguarding principles?



- Those with delegated responsibility
- Have discussions about the precise form and focus of SAR to be commissioned taken into account the following:
  - Does the case indicate that there are system conditions leading to poor safeguarding practice or communication?
  - Does intelligence from other quality assurance and feedback sources (e.g. audits/complaints) suggest the kind of practice issues in the case and/or their systemic causes are new, complex or repetitive?
  - How do the issues and the system conditions indicated in this case, relate to SAB strategic plan as well as current and future priorities?
  - Has anything similar has happened before? If a SAR was commissioned, has learning from it been implemented or and is there likely to be new learning to be identified?
  - Is there evidence of sufficient good practice to indicate the potential to explore the supportive system conditions and share learning across the partnership?
  - What is the capacity of practitioners to be openly involved at this time?
  - What is the capacity of the SAB and member agencies at this time to carry out the review and to respond meaningfully to the review outputs?
  - Is there is media interest or serious public concern?
  - What is the availability of reviewers who are sufficiently experienced or qualified to undertake the review?

#### Those providing practical support

- Does the process allow the reviewer(s) appointed to influence the scope, nature and approach for the review?
- Do the scoping document or terms of reference clearly explain the rationale for decisions about proportionality, with reference to case and contextual features as relevant?
- Is the scoping process set up to confirm requirements about the breadth and depth of the investigation, any specific areas of focus, the method or approach for assembling and analysing information, the knowledge and skills needed of reviewers and the agencies to be involved?

### **Quality Marker 6: Governance Quality statement: The Safeguarding Adult Review achieves the requirement for independence AND ownership of the findings by the Safeguarding Adults Board and member agencies**

#### Those with ultimate accountability

- Have you demonstrated strong, overt leadership about the significant degree of objectivity combined with sufficient understanding of context and organisational arrangements that is required for rigorous SAR analysis?
- Have you demonstrated clear expectations that when a consensus view cannot be reached about the analysis and findings/recommendations, the differing positions will be articulated in the final report?
- In a review involving other SABs, have you achieved clarity and agreement from the outset about who leads the SAR (e.g. area for whom most learning is likely to emerge) and governance arrangements?

#### Those with delegated responsibility

- Are senior managers being kept up to date in order to cultivate ownership of the conclusions, and avoid any surprises about the learning being identified?

- Are there mechanisms in place to allow challenge to the information and analysis of the review, so that the findings/ recommendations have been thoroughly considered before the report is finalized and taken to the SAB?
- Have quality assurance mechanisms managed the tension in a fair and balanced way, between the independence of reviewer(s) AND local involvement, and avoided agency defensiveness and inappropriate pressure?

Those providing practical support

- Have governance arrangements and who is responsible for what been set out clearly from the start?
- Has the system for quality assurance of the process and sign-off of the report been set out clearly from the start?

**Quality Marker 7: Management of the process** Quality statement: **The Safeguarding Adult Review (SAR) is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources.**

Those with ultimate accountability

- Have you made yourself available to assist in addressing any challenges that arise during the SAR?
- Does the provision of administrative support and reviewer capacity match expectations about the quality and timing of the SAR outputs?
- Is there enough slack in the plan to allow for legitimate delays?

Those with delegated responsibility

- If there have been any changes in key personnel, has there been a reflection on any impact on the SAR?

Those providing practical support

- Is there a clear plan with allocated roles and responsibilities for the transmission of information?
- Are mechanisms in place to inform the SAB Chair of any delays and reasons for them?

**Quality Marker 8: Parallel processes** Quality statement: **Where there are parallel processes the SAR is managed to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.**

Those with ultimate accountability

- Have you made and supported efforts to communicate and cooperate with all relevant processes, to achieve the best fit for the circumstances?
- Is it clear who owns documents generated through the SAR so that the relevant body can make judgements on their disclosure?

Those with delegated responsibility

- Has early contact been made with all those managing all relevant processes, to achieve the best fit between them for the circumstances?
- Have you considered any parallel processes in the terms of reference/scoping document?
- Has there been early discussion with the police/ Crown Prosecution Service (CPS) and/or coroner and the SAR and where necessary a face-to-face meeting?

Those providing practical support

- Are notes of interviews and meetings and copies of reports that might be considered relevant to criminal proceedings retained?
- Is an index being maintained, of material generated by the SAR, which might be disclosable?

**Quality Marker 9: Assembling information Quality statement: The Safeguarding Adult Review (SAR) gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors.**

Those with ultimate accountability

- Have you made it clear whether or not you expect the SAR to
- establish whether any problematic practice identified in the case was more widespread at the time and/or
- assess the current relevance of past practice issues identified in the case being reviewed?  
Does the structure of the SAR enable direct input by practitioners and managers (e.g. interviews, group meetings) as well as the person, and relevant family members or other important network members?
- Have you demonstrated clear expectations that people use the escalation pathway to you, if there is any non-engagement by participating organisations?

Those conducting the review

- Has discussion about what information is needed and what level of detail is required, been informed by the decision making about the form and focus of the SAR commissioned?
- Does the type of information identified cover:
- The facts of what happened in the case –who did what, and when?
- The rationale for decision-making, action and inaction –why did people do what they did, what were they trying to achieve, what was influencing their practice?
- How normal was their behaviour –is this the way things are usually done?
- (Where required) the current relevance of past practice issues and their systemic conditions?
- Have all sources of relevant information been considered?
- Is there sufficient clarity about the purpose of any plans, including the kind of information they are able to provide?
- In setting up practitioner events has the need for heightened group work skills to minimise the risk of harm occurring been taken into account?
- Is everyone clear about what kind of information they are looking for from different sources, be it people or paperwork?

Those providing practical support

- Has guidance been provided to participating organisations about what information is requested at the beginning of the review, and the level of detail required, and why?

- Has access been arranged for the reviewer(s) and relevant others to all the different sources of information deemed relevant?

**Quality Marker 10: Practitioners Involvement Quality statement: The Safeguarding Adult Review (SAR) enables practitioners and managers to have a constructive experience of taking part in the review.**

Those with ultimate accountability

- Have you communicated directly with practitioners invited to participate in the SAR, stressing the importance of their input, acknowledging their possible fears, clarifying the support that will be available, and the intention of creating a constructive and valuable experience for them?
- Are you planning to attend any of the practitioner events in whole or part, to reiterate your messages about the value of an open learning culture and the importance of their being able to 'tell it like it is'?
- Have you written to thank them personally once the SAR is completed?

Those conducting the review

- Is the purpose of any interviews, conversations, meetings or events that involve practitioners clear?
- Are participants being provided with clear information about the SAR and their role in it?
- Are agencies encouraging their staff to contribute their experiences and views to the SAR?
- Does the planning for the SAR include consideration of how to support individual practitioners? For example, those who played key roles in the case, or who are not part of core Safeguarding Adult Board (SAB) agencies, or are from agencies rarely involved in SARs.
- Are practitioners being provided with adequate protections within their own organisations?
- Are practitioners being provided with adequate support and protection in the planning of any group events?
- Has there been adequate consideration of whether there are any implications of the review for people now in senior management positions and if anything needs to be done to support them?

Those providing practical support

- Are participants being provided with clear information about the SAR and their role in it?
- Are there plans to gather feedback from participants about their involvement?

**Quality Marker 11: Involvement of the person and relevant family members and network Quality statement: The Safeguarding Adult Review (SAR) is informed by the person and relevant family and network members' knowledge and experiences relevant to the period under review.**

Those with ultimate accountability

- Has clear leadership been provided about the priority of enabling the person and relevant family and network members to contribute to the SAR?
- Is there clarity about why family members are being involved?
- If family members are not involved, are the reasons for non-involvement reasonable and are they documented?

#### Those conducting the review

- Does the person have support to be involved in the review, i.e. do they need statutory advocacy or any other form of support?
- Has there been discussion about which family members are involved and why?
- Is it agreed how family members are being supported to be involved?
- Is there clarity about how the person and/or their family and networks will be able to influence the focus of the review?
- Is there clarity about what the family is going to be asked?
- Has there been discussion about how the analysis will be informed by family members' knowledge and experiences relevant to the period under review?
- Has there been discussion about how families are to be represented in the final report? Are there mechanisms to allow the person and/or their family to feedback on the report before it is completed?
- Where there are criminal investigations and family members are witnesses or suspects, has the police senior investigating officer been enabled to understand the focus and scope of the review to help discussions about when and how family members can be involved?

#### Those providing practical support

- Has it been agreed who is best positioned to communicate with the family and how this will be facilitated?

**Quality Marker 12: Analysis Quality statement: The Safeguarding Adult Review (SAR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard adults.**

#### Those with ultimate accountability

- Are you championing the practical value of analysis that identifies what has led to and sustained the kind of practice problems or good practice that the case reveals?
- Are you building expectation at Board level of an analysis that seeks out causal factors and systems learning?

#### Those with delegated responsibility

- Does the assessment of practice in the case reflect the principles of Making Safeguarding Personal and the six core adult safeguarding principles?
- Is the research evidence about what constitutes good practice, being used in the analysis, up to date and accurate?
- Is it clear what specific techniques have been used to minimise the bias of hindsight and outcome knowledge on the analysis?
- Does the presentation of the analysis show the working-out process adequately, allowing the interpretation to be critiqued and counter evidence to be brought to bear?
- Where reference is made to practice beyond the case, either at the time of the case or in the present, is it clear where the knowledge about the wider safeguarding system has come from?
- Does the analysis show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice?
- Does the lead reviewer(s) access supervision or peer challenge to support the quality of analysis undertaken?

#### Those conducting the review

- Have the principles of Making Safeguarding Personal and the six core safeguarding principles underpinned your evaluation of safeguarding practice in the case?
- Has your analysis gone beyond commenting on compliance with relevant procedures, to provide explanations of professional behaviour that call on a range of cultural and organisational factors?
- Has your analysis draw attention to what professional activity in the case reveals about how service delivery worked at the time, or is working more generally and routinely?

## Outputs, Outcomes and Impact from the review

**Quality Marker 13: The Report Quality statement: The report identifies clearly and succinctly the analysis and findings of the Safeguarding Adult Review (SAR), while keeping details of the person to a minimum. Findings reflect the causal factors and systems learning the analysis has evidenced.**

### Those with ultimate accountability

- Has the report achieved the agreed commissioning specification?
- Does it provide insights into factors that increase the risk that people will not be effectively safeguarded?
- Does it illuminate conditions that are effective in enabling good safeguarding practice?
- Can you readily use it to inform work to enhance partnership working, improving outcomes for adults and families and preventing similar abuse and neglect in the future?

### Those with delegated responsibility

- Does the report get beyond description and foreground deeper analysis about social and organisational conditions that help or hinder effective, personalised safeguarding?
- Does the amount of information provided in the report satisfy the need for privacy of the adult, relevant family members and individual staff while providing sufficient information to make accessible the SAR analysis, in order that it can support necessary improvement work?
- Does the report contain findings and/or recommendations that reflect the areas deemed priority for improvement?
- Is there transparency in how conclusions have been reached?
- Does the report adequately manage accessibility and explaining complex professional and organisational issues?
- Is the tone and choice of words appropriate to the review?
- Does the structure of the report make it straightforward to identify relevant analysis, findings, and coding them for the national SARs Library?

### Those conducting the review

- Are you focused on producing a report that is succinct, accessible and useful?
- Have you included demographic detail about the person and a brief description of the harm and consequences, whilst avoiding detailed description of events? Have you focused on details relevant to the learning?
- Have you captured learning for the services and partnerships involved, that focuses on causal factors and system conditions that explain how professionals engaged with and responded to the person, relevant family, and network?
- Have you avoided over-simplifying complex problems, but presented complex issues as straightforwardly as possible?
- Have you put yourself in the shoes of the person and/or relevant family members reading the report?

Those providing practical support

- Has editorial support been arranged?
- Is legal advice necessary to inform decisions about publication?
- Have you reminded people to cross-reference the report with the commissioning specification?
- If the person and/or family have the opportunity to comment on the report, what arrangements need to be made?

**Quality Marker 14: Improvement Action Quality statement: The Board enables robust, informed discussion and agreement by agencies of what action should be taken in response to the Safeguarding Adult Review (SAR) report.**

Those with ultimate accountability

- Have you provided clear leadership about the need for an open and mutually challenging discussion about what is said in the report about the effectiveness of the safeguarding system and its component parts and what needs to be done to improve outcomes for adults and families?
- Have you planned, with those who conducted the review, how to structure and run discussions about the report findings, and relative roles in facilitating this discussion?
- Have you held preparatory discussions with relevant partner organisations to minimise defensiveness in wider discussions?
- Are there implications for the SAB strategic plan?

Those who decide the follow-up to a review

- Have you put each finding in the bigger picture of activity, strategic plans and intelligence held by agencies, to help decide priorities?
- Have you considered who is best placed to decide what an effective response to the finding would be, and how to engage them?
- Have you identified which individuals or forums have it within their gift to tackle the systems findings raised?
- Have you distinguished causal factors and conditions that are relatively straightforward to address, from those more complex and/or difficult?
- Have you considered which findings may NOT be best addressed locally and instead be taken to national, regional or other forums for discussion about how best to address them?
- Are you using a model for change management or 'organisational development' to help think wider than changes to procedures and training for staff?

Those providing practical support

- Can you help with making accessible intelligence from other sources that is relevant to findings in the report?
- Has a clear, considered process been planned, to avoid a last minute rush to agree responses?

*Quality Markers 15-17 will be developed further during the SAR Regional Champion programme.*

**Quality Marker 15: Board Written Response**

**Quality Marker 16: Publication**

**Quality Marker 17: Implementation and Evaluation**

---

<sup>i</sup> The chronology is a working document and not the IMR. It is a basis upon which the author can refer back to, and expand upon, in the analysis, etc. This should be a comprehensive chronology of involvement by the organisation and/or professionals in contact with the subject of the review, and their family, over the period of time set out in the review's terms of reference.