

1. Introduction

- 1.1 The purpose of this set of documents is to set out the roles, responsibilities, and governance arrangements for Safeguarding Adult Reviews (SAR's) and to provide information and resources to support the process.
- 1.2 It is written to reflect strong multi-agency partnerships working together to prevent abuse and neglect where possible and provide a consistent approach when responding to a request for a SAR.
- 1.3 The core duties of a Safeguarding Adults Board are set out in chapter 14 of the Care and Support Statutory Guidance, issued under s78 Care Act (2014). One of the core duties is that Safeguarding Adults Boards **must** arrange and undertake Safeguarding Adults Reviews (SAR's) when the criteria are met in accordance with s44 Care Act (2014).
- 1.4 The Enfield Safeguarding Adults Board (ESAB) policy sets out the governance arrangements that underpin its decision making on SAR's and their interaction with other learning opportunities. The protocol is guided by the Care & Support Statutory Guidance (2018) and the updated London Safeguarding Adults Policy and Procedures (2019).
- 1.5 Acknowledgement is also given to the Social Care Institute for Excellence (SCIE) and Research in Practice for Adults (RiPfa) providing guidance on SAR methodologies and Quality Markers.

2. Purpose and Principles

- 2.1 The purpose of a SAR is:
 - To identify lessons that can be learned from the case and apply those lessons to prevent similar harm occurring again.
 - For the relevant agencies and individuals involved in the case to reflect on what they might have done differently.
 - For the ESAB to determine how learning is taken forward and recommendations are implemented to promote wellbeing and better outcomes for adults at risk in its area
- 2.2 Where there is learning through other avenues the ESAB should be assured that appropriate action has been taken through its quality assurance function. Agencies may have their own internal/statutory review procedures to investigate

serious safeguarding and safety concerns e.g. Serious Incident (SI). A SAR is not intended to duplicate or replace these.

2.3 The Care Act (2014) outlines principles to be applied by SABs and their partner organisations when undertaking SAR's. Our policy endorses those principles as follows:

- Partners embrace a culture of continuous learning and improvement to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works well to promote good practice.
- Reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews are led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals from all organisations are fully engaged and involved in contributing their perspectives without fear of any blame being attributed.
- Documents and information pertinent to the Review should be shared in the spirit of effective partnership working and collective learning
- Adults and their support/advocate should understand how they are going to be involved, what the process is, and their desired outcomes included and managed appropriately and sensitively.

2.4 SAR's will be subject to consideration and due diligence to confidentiality and information sharing. Confidentiality should be maintained by all individuals and organisations. The achievement of confidentiality must be balanced against the need for transparency and sharing of information for an effective SAR to be completed in the public interest.

2.5 The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs personal consideration. The privacy and dignity of the adult at risk and sensitivity to their families and friends is required throughout the management of a SAR. Individuals will be granted anonymity within the SAR report and will be referred to by as an alias as agreed by the SAR panel.

2.6 All partners and organisations involved in a SAR are required to co-operate with and contribute to a SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming the ESAB may use its powers under s45 Care Act (2014) to obtain the relevant information. The Chair of the ESAB and/or the SAR chair or Review author may wish to review an organisation's case records and internal reports, request additional records and relevant policies/guidance, or meet with review participants.

- 2.7 The Data Protection Act (2018) and GDPR (2018) should not be a barrier to sharing information. It provides a framework to ensure that personal information about living persons is shared appropriately.

3. Criteria for a SAR

3.1 The criteria are met when:

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death;

or

- 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;

and one of the following:

- Where procedures may have failed, and the case gives rise to serious concerns about the way in which local professionals and/or services worked 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 adults at risk.

3.2 The adult at risk must need care and support, however, does not have to be in receipt of services.

3.3 Other statutory Reviews may share elements with a SAR, specifically Local Child Safeguarding Practice Review (LCSPR) and Domestic Homicide Reviews (DHR). In such instances, the ESAB Chair and appropriate local Partnerships should decide upon the relative benefits of joint or parallel approaches. Consideration should be given as to whether co-ordinated reviews or a jointly commissioned review would be appropriate.

3.4 Criminal proceedings may run in parallel to a SAR, and in such cases all material received by the SAR panel must be disclosed to the police if and as requested.

- 3.5 The Coroners and Justice Act 2009, provides the Coroner with a duty to issue reports to a person, organisation, local authority or government department or agency, where the coroner believes that action should be taken to prevent future deaths (Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, formerly known as Rule 43). Recipients are required to respond to the Chief Coroner who will in most cases publish the reports and response. If HM Coroner issues a request the ESAB should consider conducting a SAR.

4. Roles & Responsibilities

- 4.1 There is joint accountability for the management of risk, timely information sharing and co-operation when a SAR is initiated. A collegiate approach that respects boundaries and confidentiality within legal frameworks is needed to commission and execute the duties of the SAB to undertake a SAR as prescribed under s44 of the Care Act (2014).
- 4.2 It should be borne in mind that there are legislative requirements and expectations on individual services to safeguard and promote the well-being of adults in the exercise of their respective functions, relating to adults with needs for care and support and their carers.
- 4.3 **The ESAB** is the only body which commissions SAR's or suggests other learning methods following a referral for a SAR. The ESAB also has a duty to provide reasons for any decision not to proceed with a SAR when this has been requested. The ESAB is required to publish the number of referrals received and the decisions made about whether they will progress to a SAR.
- 4.4 **The SAR Chair** may be the ESAB Chair or a senior manager (head of service or above) in health and social care. This includes the NHS Integrated Care Board or Police. In some instance it may be appropriate for the SAR Chair to be from other partner agencies. The Chair holds responsibility for oversight of the SAR and leads on challenge and scrutiny of the author and report.
- 4.5 **The SAR Panel** is made up of professionals across health, social care, the police, and representatives of relevant bodies who can lead on decision making for individual organisations and contribute to decisions about the methodology, progress, quality and learning strategies. They are also responsible for holding professionals in their own organisation to account and respond in a timely manner. They take responsibility for Independent Management Reviews, ensuring access to documents and organisational policy and procedures. They represent their organisation at round table discussions.

- 4.6 **SAR Contributors** are professionals including third sector and voluntary agencies to provide information by completing chronologies, providing information and in some instances attending interviews and discussions. It is the responsibility of each partner agency to ensure these are provided by the specified deadline.
- 4.7 **The ESAB Manager** is responsible for the management of the SAR. They liaise with the report author, form a contract and set out the terms of reference for the report author. They report on the progress of the SAR to the ESAB and manage timescales.
- 4.8 **The ESAB Administrator** main role is in document control. They maintain an audit trail of minutes, decisions, report versions. They request documents on behalf of the report author and ensure compliance with the DPA (2018) and GDP Regulations.
- 4.9 **Adult/family Liaison** has a key role to work with the adult/family/advocate. They must work within the framework of Making Safeguarding Personal and keep the adult informed in consultation with the ESAB manager. They are not advocates nor counsellors and have specific responsibility to ensure good communication and raise issues on behalf of the SAR Panel and/or ESAB Manager and the adult/family.
- 4.10 **Advocates** must work to statutory requirements as detailed s68 Care Act (2014) and the Mental Capacity Act (2005) and MCA principles. Advocates are commissioned by the local authority and appointed in consultation with the adult/family support network.
- 4.11 **Report Author** works with members of the SAR Panel to define the Terms of Reference undertakes the SAR under the agreed methodology and produces a SAR Report with SMART recommendations and an Executive Summary if requested. They attend SAR Panel meetings as required and facilitate or support learning events.
- 4.12 Selection of a Report Author is based on the appropriate core skills required to provide a competent analysis of the subject. The author may be a professional employed by a partner member organisation providing that they have no previous involvement and the ESAB Chair is satisfied that there is no conflict of interest.
- 4.13 Where it is decided an independent report author is needed, the ESAB should be confident the author has proven:
- Experience of writing SAR reports
 - Ability to find and evaluate best practice
 - Good analytic skills to manage quantitative and qualitative data

- Knowledge of safeguarding adults
- Ability to write for a wide audience
- An understanding of the complexity of the health and social care system
- Good facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics

5. Commissioning a SAR

- 5.1 It is for the SAR Panel to weigh up the most appropriate and proportionate response to a SAR. No single methodology model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, take remedial action and, very often, provide answers for families and friends of adults who have died or been seriously abused or neglected. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed and to take corrective action.
- 5.2 The timescale from the decision to conduct a SAR to completion is **6 months**. If the SAR is likely to take longer for example, because of potential prejudice to related court proceedings, the adult/advocate and others should be advised in writing the reasons for the delay and kept updated on progress.

6. Quality Assurance

- 6.1 The ESAB draws on the Quality Markers produced by SCIE & RiPFA. Please refer to appendix 1, page 14.
- 6.2 Quality Assurance is embedded throughout the SAR process from selecting the report author to ensuring that the right methodology is adopted. The ESAB management of SAR's is grateful to the work of the London Safeguarding Adult Review Principles and Checklist Guidance and has adapted their quality assurance suggestions.
- 6.2 Additionally the ESAB policy is to ensure that there are challenges and scrutiny that can stand the test of rigour.
- At the start of the review, is there clarity about roles and responsibilities and are there explicitly stated governance arrangements (e.g. are the terms of reference/scoping document clear about who is responsible for what – who conducts the review, who provides quality assurance and challenge and who is ultimately accountable)?

- Is the system for quality assurance of the process and sign-off of the report set out clearly from the start?
- What are the mechanisms to allow challenge to the information and analysis of the review, so that the findings/recommendations have been thoroughly considered before the report is finalised and taken to the ESAB?
- Do the quality assurance mechanisms manage the tension between the independence of the report author and the ownership of the final report by the ESAB in a fair and balanced fashion?

7. Learning

- 7.1 The real value of the completion of a SAR is that lessons are learnt through dissemination and that local multi agency safeguarding practice is improved where required. At the conclusion of each SAR, the Adults Practice Improvement Group will request a copy of each agencies action-plan. These should address any areas for improvement identified by that agency. Action plans should include how any changes in systems and practices will be monitored through service evaluation or audit to ensure they have been effective.
- 7.2 The Adults Practice Improvement Group report to the Board and provide information about SAR practice standards and regional and national direction of travel. The Adults Practice Improvement Group together with the Board Manager and Officer maintain quantitative and qualitative data to share appropriately and within the Board's policy on information governance.
- 7.3 The Adults Practice Improvement Group focus on:
- Evaluation of practice
 - Systems findings i.e. the social and organisational conditions that impact beyond the single SAR
- 7.4 The Adults Practice Improvement Group maintains oversight to ensure that the procedure for learning is:
- Focussed
 - Succinct and provides sufficient detail for understanding/discussion
 - Accessible to all levels of experience
 - Enables organisations to build on good safeguarding practice
 - Provides insight on preventative measures
 - Supports recovery and resilience

- 7.5 The ESAB guiding principle is proportionality and the Adults Practice Improvement Group acts as the advisory body for the dissemination of SAR's in consultation with the independent ESAB chair.
- 7.6 The Adults Practice Improvement Group considers the final report and ensures any learning within the sub-groups terms of reference are incorporated into a SMART action plan for the SAB. The SAB action plan is coordinated by the Board Manager and should ensure that learning is incorporated into all aspects of the boards work.

8. Publicity and Media Management

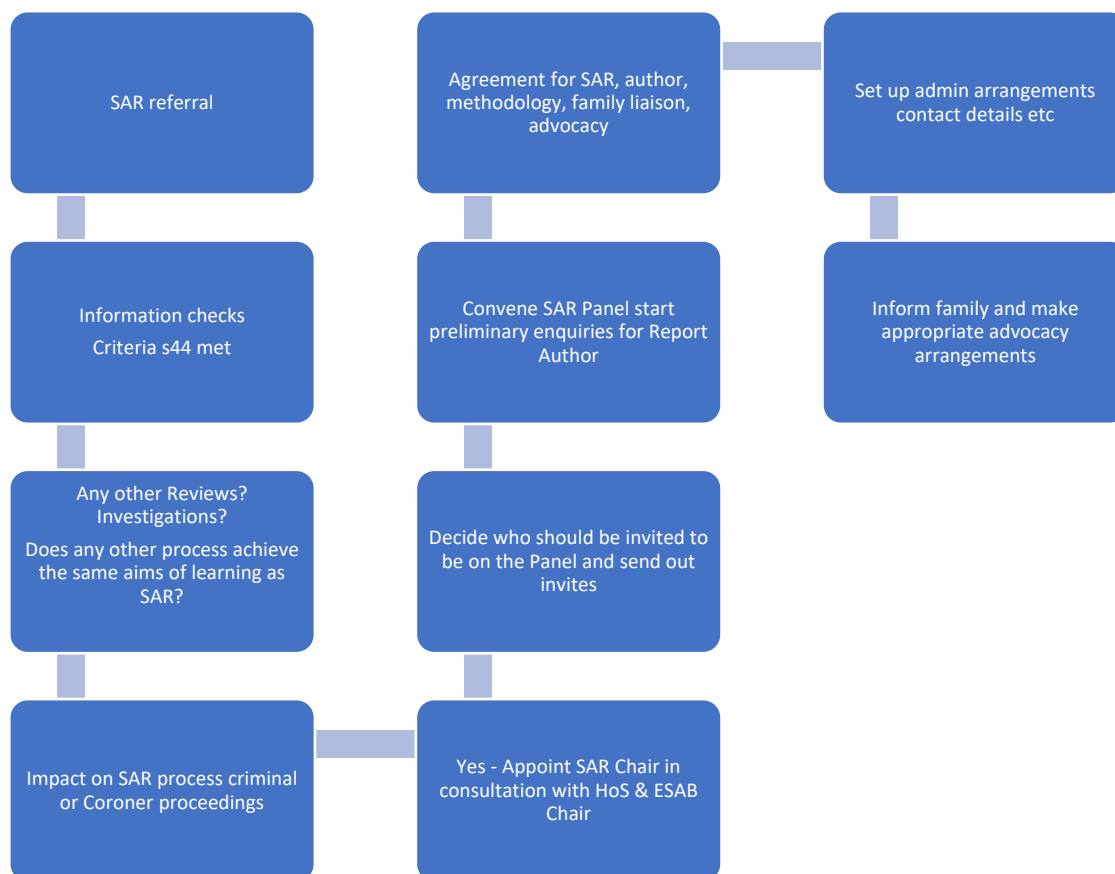
- 8.1 The ESAB publishes reports in full and they are available on the local authority website. All names are anonymised. In cases where consideration is needed for the potential of legal challenge or significant impact on public confidence the ESAB chair will lead on discussion with the local authority, legal department, and relevant organisations and teams.
- 8.2 Consideration should be given to ESAB taking the lead in developing a press statement, being agreed where possible by the various organisations involved. Consideration should also be given to a press briefing/conference being necessary or helpful.

9. Process

Request for a SAR

- 9.1 A request for a SAR must be made in writing using the SAR Request Form. (Resource 1). Telephone referrals are not taken but the referrer may phone the Safeguarding Adult Board Business Unit (SAB BU) for advice.
- 9.2 Referrers should in the first instance discuss the case with their line manager and follow their own organisation's reporting process.
- 9.3 Upon receipt of the referral the SAB BU will log the case, ensure with the referrer that the adult is no longer at risk and that other adults are safe. If additional concerns are raised about other vulnerable adults or children these should follow the statutory safeguarding route.

SAR Decision Making



Referral Meeting (Pre SAR)

9.4 The SAB BU should advise the ESAB Chair of the request and set a date for the pre-SAR meeting. ESAB Chair, LBE Head of Safeguarding Adults & Quality, the Chair of the Adults Practice Improvement Group, and one other statutory partner member of the ESAB. This may be from the police or the NHS Integrated Care Board. In the absence of other statutory partners, at least one other Board member should be invited to the discussion.

9.5 The meeting decisions are based on the presenting referral. The ESAB Chair has the final decision. Recording of decisions and outcome are sent to the referrer.

9.6 If there is insufficient information the referrer is offered the opportunity to make one further request with additional information. If there is a dispute, Board partners may ask for an exceptional meeting with the ESAB Chair. In such circumstances the referrer must follow their own line management process.

SAR Initiation

9.7 If the decision to progress with a SAR is made the lead officer responsible for managing the SAR is the ESAB Manager supported by the ESAB administrator. The ESAB Chair must be kept informed of any unexpected challenges.

9.8 The Pre-SAR meeting members will appoint a SAR Panel Chair, identify organisations to include in a SAR Panel and advise the ESAB Manager on commissioning a Report Author.

9.9 A SAR Panel meeting is convened and follows the agenda and format set out in the SAR Resource pack. SAR Panel Members must attend meetings and implement actions within specified timescales.

9.10 Invited members must advise the SAR Chair as soon as possible if their organisation has initiated any other action or unable to complete agreed tasks. All correspondence must be copied to the ESAB Manager & Admin so that there is a clear audit trail of decisions and actions

9.11 The preferred methodology for the SAR will determine how it is progressed. The SAR resources document (September 2025) includes SCIE's SAR methodologies.

9.12 Further SAR Panel Meetings will be convened at the request of the Report Author or the SAR Chair. At a minimum there will be at least one other meeting prior to the final report.

9.13 Organisations and IMR authors must have the opportunity to challenge factual information. It may also be helpful for organisations to share any changes they may already have implemented.

9.14 Recommendations should be SMART, and organisations given the opportunity of advising viability without compromising the independence of the SAR process.

10. Making Safeguarding Personal

10.1 The views of the adult or their representative should be central to the learning from a SAR. Communication should be established at the earliest opportunity and

advocacy provided to support the adult or their representative. Information should be given about how the SAR will be conducted and how they can be involved.

- 10.2 It is important that the adult and/or their representative have clarity about the purpose of a SAR. Their views about what learning might have made a difference to them and what they think might better safeguard people should be given weight in the terms of reference.
- 10.3 Consultation with adults at risk/representative and their involvement needs to be balanced with the overall wellbeing of the individuals involved. Throughout the process due diligence, compassion and appropriate support should be provided by the most appropriate organisation.
- 10.4 Where the adult at risk, family and friends are not to be informed or involved, the rationale for this must be clearly documented. This should only be in exceptional circumstances.
- 10.5 Notifying adults/representatives should be considered on a case by case basis. Who is best placed needs to work closely with designated family liaison and the ESAB Manager. Communication should be clear and consistent between all designated supporters including independent advocates.
- 10.6 Where appropriate, the Independent Author will offer to meet with those individuals to hear their views and explain the process, highlighting the purpose of the review.

Notifying Person(s) or Organisation(s) Alleged to Have Caused Harm

- 10.7 It is important to consider the Person(s) or Organisation(s) Alleged to Have Caused Harm, as they can play a valuable role in the SAR process. Each case shall be considered on a case by case basis by the SAR Panel to ensure a holistic view has been represented to gain the maximum benefits from the SAR process.

11. Board Presentation & Ratification

- 11.1 The full report and Executive Summary are formally presented to the ESAB by the Report Author. The ESAB Manager arranges all paperwork for the Board's official ratification.
- 11.2 The presentation aim is to facilitate discussion, invite scrutiny and to elaborate on recommendations. The Executive Summary should provide succinct detail of the case so discussion is focussed on achieving improved safeguarding outcomes as a result of recommendations.

- 11.3 Following acceptance of the Report and its recommendations the Adults Practice Improvement Group will produce a multi-agency action plan and follow up as in Section 7. Updates and completed action plans must be reported to the Board for a final sign off.
- 11.4 Findings and recommendations from a SAR must be included in the Annual Report together with actions intended or complete

Appendix 1: Safeguarding Adult Review Quality Markers Checklist (2018) www.scie.org

- 1.** The case is referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner
- 2.** 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.
- 3.** 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.
- 4.** 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.** 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.
- 6.** The Safeguarding Adult Review achieves the requirement for independence AND ownership of the findings by the Safeguarding Adults Board and member agencies
- 7.** The Safeguarding Adult Review (SAR) is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources.
- 8.** 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.** 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.** The Safeguarding Adult Review (SAR) enables practitioners and managers to have a constructive experience of taking part in the review.
- 11.** 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.
- 12.** 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.
- 13.** 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.** 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.