London Boroughs of Richmond and Wandsworth Safeguarding Adults Board

LOCAL SAFEGUARDING ADULT REVIEW (SAR) PROTOCOL

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

Previous Version	November 2021
Version	4
Date	November 2023
Next Review	November 2025

CONTENTS

Context and local references

This protocol has been revised since the 2014 Care Act Guidance.

It should be read in conjunction with the London Multi-agency Safeguarding Procedures.

1. INTRODUCTION

1.1. Section 44 of The Care Act 2014[1], requires Safeguarding Adult Boards (SABs) to arrange Safeguarding Adult Reviews (SARs) when the criteria are met, and when they are not met but the SAB believes there is value in doing so.

1.2. The Care Act 2014 requires the SAB to determine if a SAR is necessary, arrange for its conduct and ensure any required changes are implemented by partners. All members of the SAB are legally required[2] to co-operate in and contribute to the SAR in order to identify learnings and apply these to future cases.

1.3. This Protocol has been developed by the Richmond and Wandsworth SAB (RWSAB) to support the partnership in identifying and conducting SARs. It describes the process to follow and must be read in conjunction with the Care and Support Statutory Guidance and the London Multi-agency Safeguarding Policy.

2. GOVERNANCE

2.1. The RWSAB has the statutory responsibility for determining whether a SAR is required, making arrangements for it to be carried out and ensuring that learning is shared, and corrective actions completed. In RWSAB this function is discharged through the SAB Executive Group. Details of the SAB Executive's Terms of Reference and membership can be found on the RWSAB website.

2.2. The SAB Executive Group has delegated responsibility for screening referrals and arranging for reviews to be completed to the SAR Sub-group. Details of the SAR Sub-group's Terms of Reference and membership can be found on the RWSAB website.

3. PURPOSE OF A SAFEGUARDING ADULT REVIEW

3.1. The purpose of a SAR is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for the case should be applied to future cases to ensure continuous improvement of practice.

3.2. The 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, etc.

3.3. It will be highly likely that a safeguarding process will have been followed in relation to the circumstances of the case. The SAR is for consideration of the most serious

[1] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
[2] See section 45 (5) of Care Act 2014

issues and will not be an alternative to a safeguarding enquiry, investigation or process, however, there should be consideration of whether a SAR might be more effective than a Section 42 enquiry if the latter has not commenced when consideration is being given to making a SAR referral.

4. CRITERIA FOR SAFEGUARDING ADULT REVIEW

4.1. The RWSAB **MUST** conduct a SAR when:

- An adult in its area dies as a result of abuse or neglect **AND**
- there is concern that partner agencies could have worked more effectively to protect the adult **OR**
- where an adult is still alive but has experienced serious abuse or neglect.

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

- It is likely that an individual would have died if not for an intervention;
- the individual suffered permanent harm as a result of abuse or neglect;
- the abuse or neglect led to reduced capacity or quality of life (whether because of physical or psychological effects).

4.3. The RWSAB **MAY** agree to undertake a SAR where the criteria in 4.1 are not met but the RWSAB believes there is value in doing so. This will be including learning from 'near misses' and situations where the arrangements worked especially well, and that learning can be applied to future cases.

4.4. It is important to remember that the person referred for a SAR needs to have care and support needs, however these do not need to be met by any statutory or other agency.

4.5. The person who is referred to RWSAB must live (or have died) within Richmond and Wandsworth Councils areas. Any person who ordinarily lives in a different area will need to be referred to the local SAB. In some circumstance e.g. where the person has been in a number of Boroughs the RWSAB may agree to jointly commission a SAR with other SABs.

5. REFERRAL AND DECISION-MAKING PROCESS

5.1. Any agency, individual or professional may make a SAR referral. It is expected that any request is first considered by the agency or organisation for whom the professional works, and that the most senior manager or their RWSAB representative makes any formal referral. The referral should clearly outline the reasons the referrer is making the referral with reference to section 4 of this guidance.

5.2 The formal referral to the RWSAB should be made using the Referral Notice form in Appendix 1 to the SAB via email. Details for submission are set out on the form in Appendix 1 (also available online).

5.2. All referrals will be screened in relation to the criteria (see 4 above) and presented to the SAR Sub-Group to make a recommendation to the Executive Group on whether the RWSAB should undertake a SAR. The SAR Sub-group will be convened within at least 6 weeks of the referral being received.

5.3. Referrers could be invited to present the case at the SAR Sub-group meeting to clarify case details.

5.4. The SAR Sub-group will seek to identify at the outset what other reviews and processes are taking place or envisaged in relation to the same event, e.g.:

- Criminal court case;
- Health and Safety Executive investigation;
- Domestic Homicide Review;
- Mental Health Homicide review;
- Coroners enquiry;
- Child serious care review;
- NHS Patient Safety Incident Response Framework (PSIRF) review;
- Learning Disability Mortality Review;
- Police Professional Standards Investigation.

5.5. There will be early liaison with the decision-makers in any related review process to determine how the reviews can be effectively managed to maximise learning for individuals and organisations, and to avoid duplication for families and professionals.

5.6. The SAR Sub-group will make a recommendation to the SAB Executive who will make the final decisions. The reasons for the final decisions will be clearly documented in the SAB Executive minutes.

5.7. Feedback to referrers on the RWSAB decision will be provided on behalf of the SAB Executive.

6. ARRANGING A SAFEGUARDING ADULT REVIEW

6.1. Once the SAB Executive have agreed for the RWSAB to undertake a SAR, the SAR sub-group will agree the teams of reference for the SAR, taking into account the 6 safeguarding principles in the Care Act (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability).

6.2. The Terms of Reference document will include:

- Rationale for undertaking a SAR;
- Scope;
- Involved agencies;
- Issues which the review will focus on;
- Methodology to be used (see flow chart in Appendix 4);

- Timescale for completion (which is usually 6 months after the reviewer has been appointed);
- Person and family involvement and support;
- How reviewer will be selected, and any cost associated with this.

6.3. Once the SAR Sub-group have agreed the Terms of Reference, the senior Accountable Officer of each involved agency will be notified in writing that a SAR is to take place. (see Appendix 2 for standard letter of notice) They will be asked to nominate representatives who will ensure the full engagement of their organisation in the process and to supply a chronology (See Appendix 3 for key event chronology template). Note Section 45 of the Care Act requires all agencies to supply the SAB with information for a SAR when requested to do so.

6.4. A lead reviewer, who has no previous involvement in the case management and no conflicts of interest, will be appointed for each SAR. Where there is a need for an external reviewer to be appointed, this will be undertaken using the Councils' procurement procedures.

6.5. The reviewer must have the appropriate skills and be able to lead a SAR process which encourages openness, and which is focussed on identifying system learning. The reviewer should also be able to produce a SAR report which fulfils the RWSAB terms of reference for the SAR and is compliant with London ADASS quality markers.

6.6. The SAB co-ordinator will contact agency representatives to advise them of any activities they need to undertake e.g. prepare IMR, attending SAR panel meeting, etc.

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

7.1. Involving the adult at risk (if they have survived) and/or their family is significant to the SAR process. The purpose of a SAR and the process it follows will be unfamiliar for the adult at risk and/or their family, adding to their distress and inevitable concerns. It will be a very sensitive time for everyone, and consideration should be given at an early stage as to how this will be done. Decisions will be made early on about how the adult at risk and/or their families will be supported and by whom.

7.2. The adult at risk and/or their families will be advised in writing about what to expect from the SAR process and how they could be involved. (See Appendix 5 for template letter). The reviewer/s when commissioned should also arrange to meet with them at the beginning and end of the SAR to consider how they want to be involved, influence the terms of reference and recommendations, clarify the purpose of the report and have sight of final draft and be able to comment on that. In addition, adults at risk and/or their families could be supplied with the RWSAB leaflet for families.

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

8.1. As soon as a SAR has been agreed, involved professionals should be advised that a SAR is being conducted and of the role they will be required to fulfil. The nature, scope and timescale of the SAR should be made clear at the earliest possible stage to involved professionals and their line managers. It should be understood that the review process can be lengthy.

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

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

8.4. Where concerns about an individual's practice or professional conduct are raised through the SAR process, it remains the responsibility of the individual agency to trigger any action in proportion with the concerns.

8.5. At the conclusion of the SAR each agency should consider the best way to involve staff and others in disseminating learning that has been identified, and to ensure oversight of practice that subsequently changes.

9. SAFEGUARDING ADULT REVIEW REPORTS AND RECOMMENDATIONS

9.1. There must always be an anonymised final SAR report which has been agreed by all stakeholders involved in the SAR and which outlines the following:

- What happened;
- Any errors or problematic practice and/or what could have been done differently;
- Why those errors or problematic practice occurred and/or why things weren't done differently;
- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases so become findings (system findings)?

9.2. The report must be accompanied by a composite action plan which identifies the actions to be taken in response to system findings to help prevent similar harm in future cases. (See template in Appendix 6).

9.3. The SAR Sub-group will quality assure the SAR report and present a draft Board response and agreed action plan to the SAB Executive for final sign off.

9.4. The SAB Co-ordinator will make appropriate arrangements for the SAR report and documentation to be held securely and confidentially for an appropriate period of time in line with prevailing Information Sharing Agreements, the Data Protection Act, GDPR, Information Governance arrangement and other legal requirements.

10. PUBLISHING REPORTS

10.1. The final report will be circulated to all involved partners, with a 7-minute learning summary, to promote shared learning.

10.2. The SAB Executive will decide how much of the final SAR documentation will be made available on the RWSAB website. It will only be in exceptional circumstances where the SAR report will not be published in full. All SAR system findings will be submitted to the national SAR library.

10.3. The findings of each SAR will be summarised in the RWSAB Annual Report, as required by the Care Act 2014.

10.4. The SAR Sub-Group will ensure that all agreed actions are completed and will regularly report on progress to the SAB Executive.

11. FINDINGS, LEARNING LESSONS AND IMPLEMENTING RECOMMENDATIONS

11.1. The real value of a SAR is to ensure that the relevant lessons are shared as widely as possible within the partnership and that these are used to shape and improve practice in order to do everything possible to prevent the issues in question happening again.

11.2. The RWSAB will ensure that 7-minute learning summaries are sent to all partners with a request for this to be disseminated and discussed within their organisations and to feedback to the RWSAB on this.

12. REVIEW OF PROTOCOL

12.1. This protocol will be reviewed within two years but may be updated earlier in response to any agreed changes.

APPENDIX 1: Making a Safeguarding Adult Review referral

Form A: REFERRAL NOTICE

REFERRAL INFORMATION	
Name of person making the referral:	
Name of your Agency:	
Job title:	
Your email:	
Your address:	
Your telephone number:	
Date of referral:	
IDENTIFYING INFORMATION	
Name of person(s) being referred:	
Date of birth(s)	
Age at time of incident or death:	
Date of incident or issues (please give time range if more appropriate)	
Date of death [if applicable]	
Gender:	
Ethnicity:	

SUBMISSION DETAILS	
Email to sab@richmondandwandsworth.gov.uk	**By Post to:** **Richmond and Wandsworth Safeguarding Adults Board** Adult Social Care – Safeguarding Team Town Hall Extension, 6th Floor Wandsworth High Street SW18 2PU

REASON FOR REFERRAL

(Do not exceed 4 sides of A4 text)

The **purpose** of a SAR is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The aim is that lessons can be learnt for the case and applied to future cases to prevent similar harm re-occurring. The purpose is **NOT** to hold any individual or organisation to account.

Why are you referring this case for Safeguarding Adult Review? *In making your referral for Safeguarding Adult Review, you should consult the local policy, setting out your reasons as to why the criteria is met – please tick the appropriate boxes below.*

The criteria you should consider are:

- ☐ An adult in its area dies as a result of abuse or neglect

  AND

- ☐ there is concern that partner agencies could have worked more effectively to protect the adult

  OR

- ☐ Where an adult is still alive but has experienced serious abuse or neglect;
- ☐ The criteria above are not met but the referrer believes there is value in doing a review for learning, which can be applied to future cases.

Please include details of any safeguarding meetings held, and names of Social Workers or Safeguarding Adults Managers or others involved in the case.

Case summary

[Insert your summary of the case. As far as is possible, ensure all involved agencies' activities are included in your summary]

Agencies and persons involved

[*Please provide detailed information about agencies and professionals involved in the case, and any parallel processes and meetings already happening.]*

Main family contact

[please include full names, full postal address, email address and other contact details known for the main family contact for the case]

Names:
Postal address:

Email address:
Phone number:

PARALLEL PROCESSES

*Have any other processes commenced which are looking at this case **and/or** are you aware of any that may likely to be instigated. Please tick the relevant boxes, and where another process has started or is likely to start, please give details below*

Please tick as applicable:

Process	**Commenced**		**Planned**	
	Yes	**No**	**Yes**	**No**
Section 42 Adult Safeguarding Enquiry	☐	☐	☐	☐
Criminal Investigation	☐	☐	☐	☐
Domestic Homicide Review (DHR)	☐	☐	☐	☐
Mental Health Homicide Review (MHHR)	☐	☐	☐	☐
NHS Patient Safety Incident Response Framework (PSIRF)	☐	☐	☐	☐
Coroner's Inquest	☐	☐	☐	☐
Serious Case Review (Children)	☐	☐	☐	☐
Other	☐	☐	☐	☐
'Other' – please state:				
Lead contact for each of the processes identified above *[where known]*				

Completed by [Name]:	
Job title:	

APPENDIX 2: Initial letter of notice about SAR

Dear [insert name]

Re: NOTICE OF SAFEGUARDING ADULT REVIEW

Name of Person: John Bloggs (JB)
Date of Birth: 08/08/2025

A decision has been made to undertake a Safeguarding Adult Review (SAR) in terms of section 44 of the Care Act, for the above-named person.

The purpose of a SAR is:

- To promote effective learning and improvement to services and how they work together;
- To learn lessons about how the local safeguarding system works which will help to reduce the likelihood of future harm;
- To understand what happened and why.

The relevant dates to be considered cover from [date] to [date].

Each agency will be required to:

- Identify lead contact for the SAB on this case and notify the SAB via email by [date] of names and contact details.
- Prepare a key event chronology of your agency's involvement between [dates]. This will be required by [date].

Please send contact details and chronology to SAB@richmondandwandsworth.gov.uk

Yours sincerely,

Chair, Safeguarding Adult Review Sub-group
Richmond and Wandsworth SAB

APPENDIX 3: Significant Event Chronology

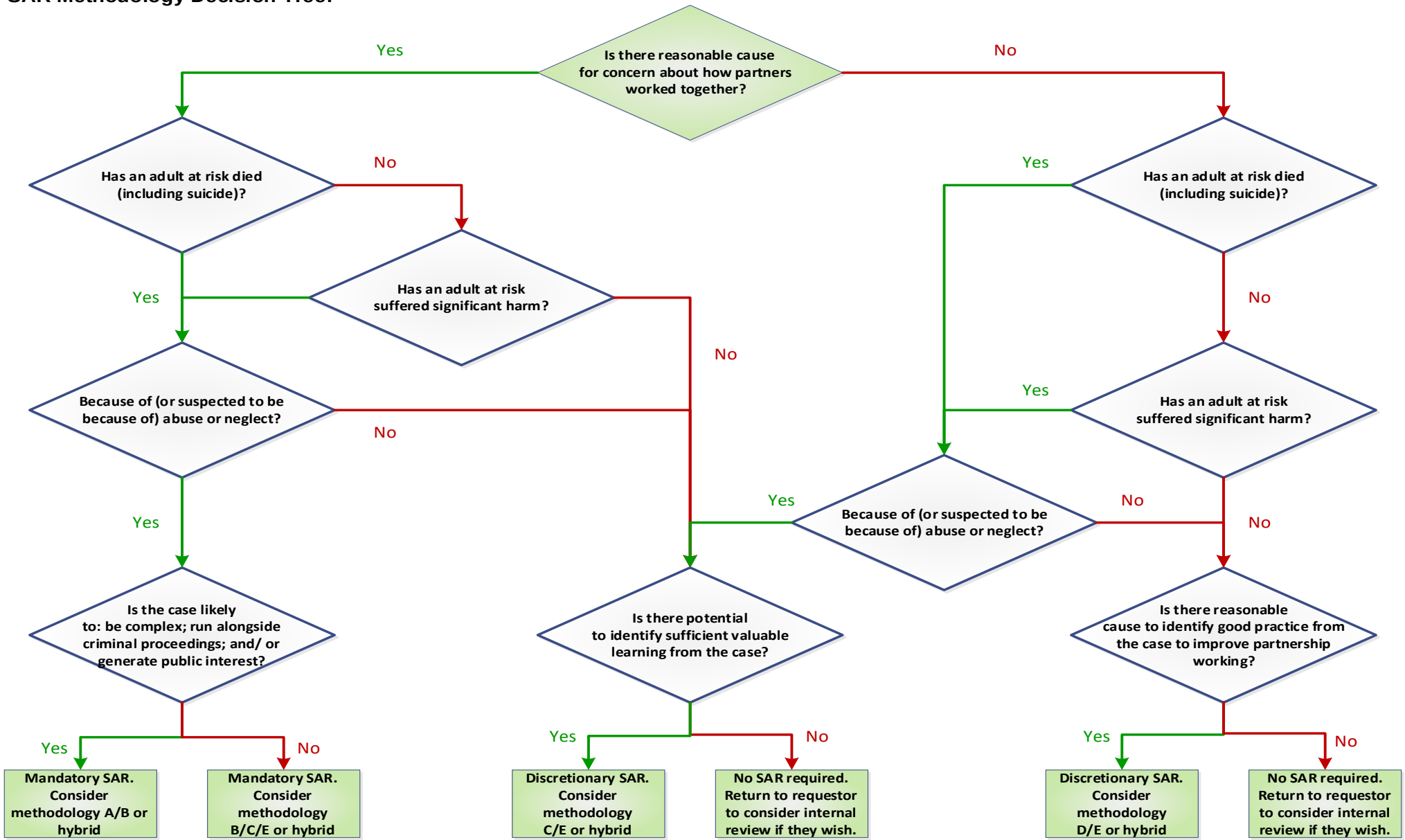
A chronology of each agencies actions is a starting point for all SARs. Agencies are required to complete a chronology outlining all significant activities undertake. It is helpful to also articulate where agencies were unable to complete an expected action or missed a deadline.

The chronology should be completed in excel with a consistent date format and details of agency and team involved. The usual format is outlined below:

Date	**Actions/activities**	**Agency**	**Team** *[where applicable]*
dd/mm/yyyy	Summary of actions taken or due to be taken. Observations and reasoning		

APPENDIX 4: SAR Methodologies

SAR Methodology Decision Tree:

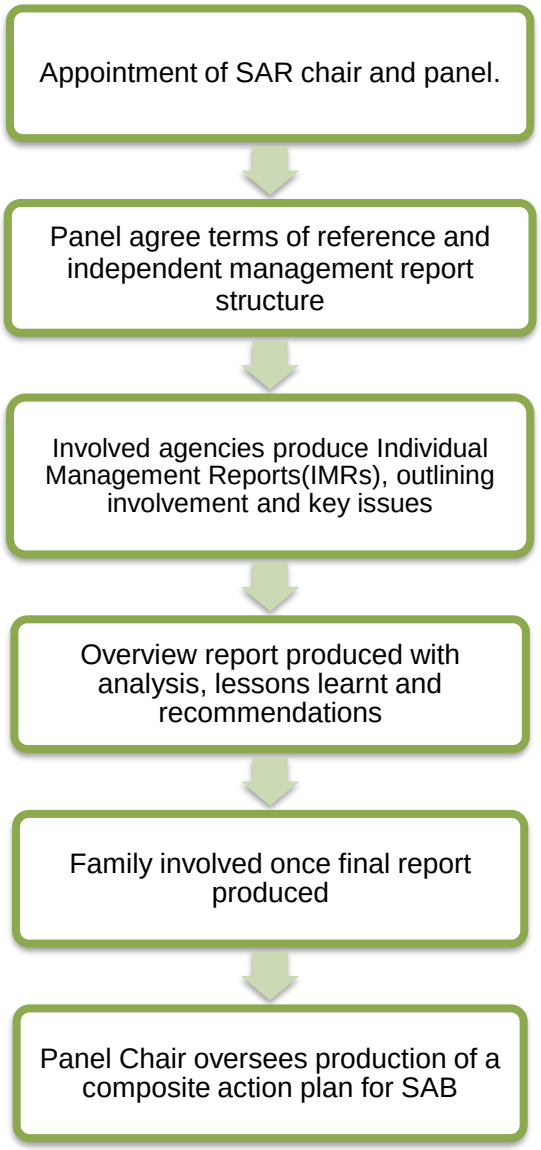


OPTION A: Traditional Approach

Key features:

- Independent Author
- Formal panel (senior managers not involved in case)
- Panel is fixed and responsible for terms of reference and quality assure findings
- Each agency prepare Individual Management Reports (IMRs) based on review of their agency files
- Family involved as agreed
- Provides analysis of what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
✓ Methodology usually reflects that of Children SCRs/Domestic Homicide Reviews (DHR). ✓ Public/political confidence is more likely to be assured via a tried and tested approach. ✓ Familiar to stakeholders, who may consider it more robust/objective. ✓ Brings a strong level of independence and scrutiny. ✓ Composite action plan offers clear governance of implementation of necessary practice and system changes.	× Perceived as overly bureaucratic × Structured process may mean it's not light touch. × Protracted implementation of lessons learnt/recommendations may not be sufficiently responsive to time considerations. × Can be costly - costs may not justify the outcomes. × Can be perceived punitive, attributing blame which is not the focus of a SAR × Frontline staff often feel/are excluded and disengage from process and subsequent learning. × Family involvement limited to receiving report.

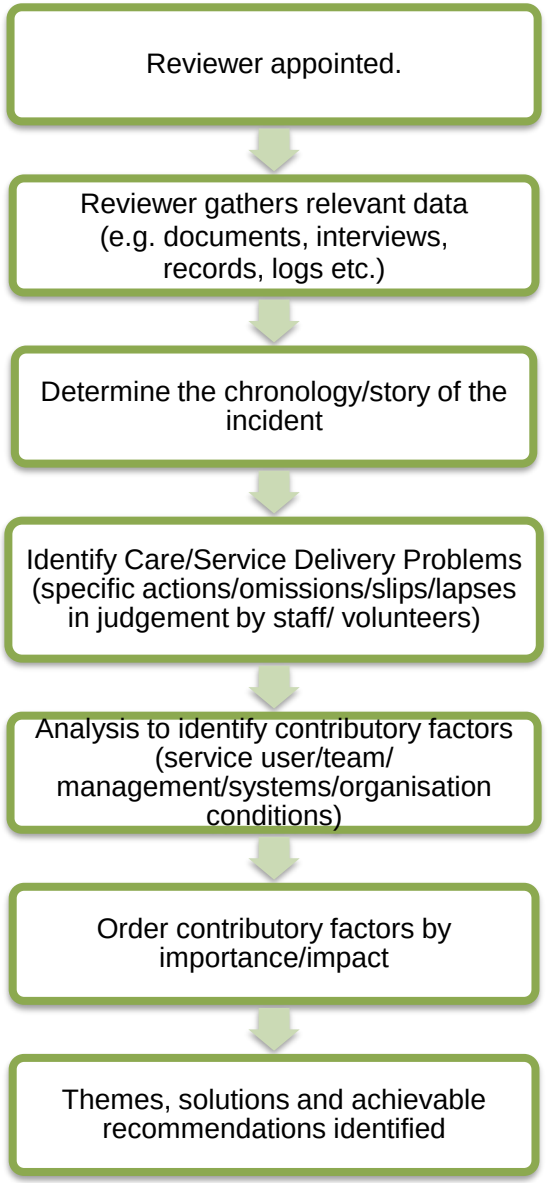


OPTION B: Root Cause Analysis

Key features:

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

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



OPTION C: Learning Together

Key features:

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

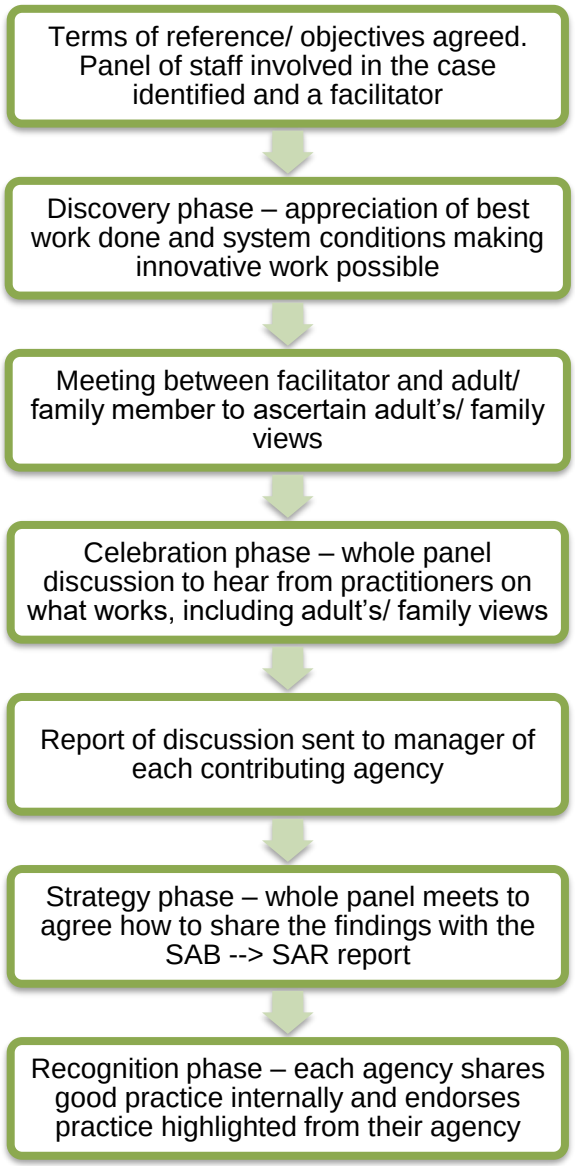
Advantages	Disadvantages
✓ Structured process of reflection. ✓ Reduced burden on individual agencies to produce management reports. ✓ Front line professionals describe the conditions prevailing during the incident and participate fully in process ✓ Family members views are encouraged to shape final report. ✓ Group of senior managers analyses the events together arriving at a balanced view. ✓ Enables identification of multiple causes/ contributory factors and multiple causes ✓ Tried and tested in children's safeguarding. ✓ Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity. ✓ Tools can be applied flexibly and can be as light touch or intense as SAB requires. ✓ Range of pre-existing analysis tools available. ✓ SAB actively involved in shaping the action plan	× Burden of analysis falls on small team/ individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions. × Challenge of managing the process with large numbers of professionals/family involved. × Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses. × Unfamiliar process to most SAB members.

OPTION D: Appreciative Enquiry

Key features:

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

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

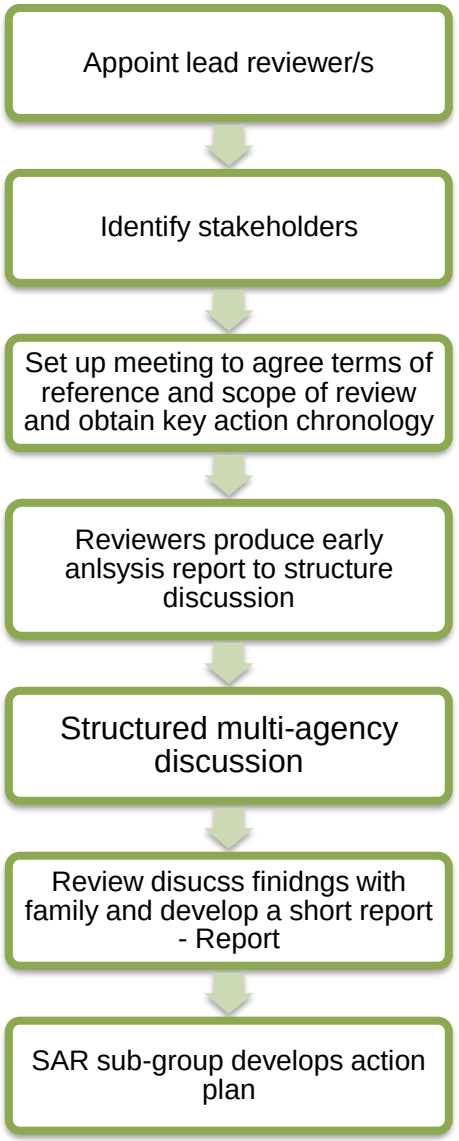


OPTION E: SAR in Rapid Time

Key features:

- Lead reviewer led.
- Co-designed with all participants conversations.
- No single agency management reports.
- Final report is short
- Completed within short timescale
- Significant event chronology.
- Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages	Disadvantages
✓ Completed quickly and takes limited practitioner and manager time ✓ Learnings able to be shared in real time ✓ Structured process of reflection. ✓ Reduced burden on individual agencies to produce management reports. ✓ Involves front line professionals and managers in reflective dialogue across agencies ✓ Family members views are encouraged to shape final report. ✓ Enables identification of root causes and system contributory factors ✓ Rooted in working together methodology ✓ Tools can be applied flexibly and can be as light touch or intense as SAB requires. ✓ Range of pre-existing analysis tools available. ✓ SAB actively involved in shaping the action plan	× Challenge of managing the process with large numbers of professionals/family involved. × Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses. × Unfamiliar process to most SAB members.



APPENDIX 5: Letter to person/family

Dear XXXX,

Re: [full names of person SAR case is conducted for]

I am writing to you as the named family representative of the late XXXX to inform you that Richmond and Wandsworth Safeguarding Adults Board (RWSAB) has made the decision to undertake a Safeguarding Adult Review (SAR) into the circumstances surrounding XXXX's death/incident *[delete as appropriate]*.

The objective of the Safeguarding Adult Review is for involved agencies to identify ways in which they can work together more effectively to protect people. The focus is not on apportioning blame but to focus on improving the way organisations work together, identify lessons and recommendations and recognise any best practice.

As part of the process, the reviewers will offer to meet with you to explain how they will work and also once there is a final draft of the review, to discuss your views on the findings. Please let the Safeguarding Board Co-ordinator know via email at SAB@richmondandwandsworth.gov.uk if you would like to meet with the reviewers to understand more about how the process works.

Yours sincerely,

Chair of the SAR Sub-group
Richmond & Wandsworth Safeguarding Adults Board

APPENDIX 6: Composite Action Plan

A Composite Action Plan is an outcome of SARs, where the system findings from the review result in actions for one or more agencies, in order to ensure any identified gaps or system issues are addressed. The usual format is outlined below:

Finding	Recommendation	Action	Outcome	Lead agency and person	Completion date
1 – finding identified in the SAR	**1 -**	1.			dd/mm/yyyy
		2.			dd/mm/yyyy