Hounslow
SAFEGUARDING
ADULTS
Board

Safeguarding Adults Review Policy and Procedure

UPDATED APRIL 2025

Safeguarding Adults Review policy and procedure

1. Policy

This policy should be read in conjunction with the *London Multi-Agency Adult Safeguarding Policy and Procedures*[1] which details the policy context and procedure for adult safeguarding in London.

The Care Act 2014 sets out the circumstances in which the local Safeguarding Adults Board is required to commission a Safeguarding Adults Review (previously known as a Serious Care Review). Section 44 states:

(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2)Condition 1 is met if—

(a) the adult has died, and

(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3)Condition 2 is met if—

(a) the adult is still alive, and

(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the Safeguarding Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learned from the adult's case, and

(b) applying those lessons to future cases.

The *Care and Support Statutory Guidance*[2] goes on to state the Safeguarding Adults Board should

[1] London multi-agency adult safeguarding policy and procedures – updated August 2016
[2] Care and Support Statutory Guidance, Issued under the Care Act 2014, Department of Health October 2014

- Determine the type of review in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.
- Explore examples of good practice where this is likely to identify lessons that can be applied to future cases.
- Ensure that early discussions should take place with the adult, family and friends to agree how they wish to be involved. Communication should be maintained throughout the review. In some circumstances this will include the person alleged to have caused harm.

Safeguarding Adults Boards should agree Terms of Reference for any review they arrange, and these should be published and openly available. When undertaking Safeguarding Adults Reviews the records should either be anonymised through redaction or consent should be sought.

The following principles should be applied by SABs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families should be invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.

A Safeguarding Adults Review is not designed to hold any individual or organisation to account. Although other processes exist for this purpose (including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation) the process should respect natural justice and due process[3]. Reviews should be conducted in an open way in order to encourage honesty, transparency and sharing of information.

It is expected that those undertaking a review will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others.
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.

[3] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013 page 17

- collaborative problem-solving experience and knowledge of participative approaches.
- good analytic skills and ability to manage qualitative data.
- safeguarding knowledge.
- inclined to promote an open, reflective learning culture.

The SAB should aim for completion of a SAR within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required.

There may be occasions when Safeguarding Adults Reviews are conducted in parallel with other types of review. Board members from partner agencies should offer advice and assistance in framing appropriate terms of reference and prevent duplication[4]. These will include:

- Domestic Homicide Reviews[5]
- Children's Serious Case Review[6]
- Coroner's enquiries and inquests[7]
- Criminal investigations
- Mental Health Reviews
- Learning Disability Mortality Reviews

The Safeguarding Adults Board should publish findings from any reviews in its Annual Report. Safeguarding Adults Review reports should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

The board should publish a summary of the:

- Action it has taken or intends to take in relation to those findings.
- Or why the board decides not to implement any recommendations from a review

A range of methods of completing reviews have been developed. This policy is based on

The Social Care Institute for Excellence (SCIE) has piloted Learning Together Reviews[8] system approach to meet these objectives. It is based on a series of conversations with key professionals and family members. It encompasses a range

[4] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013 page 26
[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Revised – applicable to all notifications made from and including 1 August 2013
[6] Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, March 2013
[7] https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner
[8] http://www.scie.org.uk/children/learningtogether/services/reviews.asp At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews Published: January 2012

of reviews that can be used dependent on the issue identified: the most serious issues would require a full review. The review types include:

- **Full:** Involves individual conversations with all key staff involved in the case (case group), approximately five planning and analysis meetings of senior managers and lead reviewers (review team) and two joint meetings between the review team and case group. It is usually spread out evenly over a six-month period.
- **Intensive:** A full review arranged around two key blocks of activity. With appropriate lead in time; it can be completed within a shorter time period.
- **Speed+:** Based on the peer review model, completed within a single week, plus or minus an additional meeting to review the findings. Report writing time is in addition. This requires significant lead in time.
- **Mid-range:** This involves a limited number of conversations with frontline staff, usually not more than six. There are often fewer meetings of the review team and case group.
- **Focused:** Revolves around a one-day event for all involved staff. There are no individual conversations and a limited number of review team planning and analysis meetings. Report writing takes place afterwards.
- **Themed:** Blending audit and review, this incorporates breadth and depth of learning. It is a two staged process which starts with case file auditing on a theme and is then supplemented by a focused review or reviews. This can be single or multi-agency.

Root Cause Analysis[9] offers a *Levels of severity of Patient Safety Incidents*[10] when combined with the review type offers a clear means of distinguishing the type of review required. These are:

- **None**: A situation where no harm occurred: either a Prevented Patient Safety Incident or a No Harm Patient Safety Incident.
- **Low**: Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm, to one or more persons.
- **Moderate**: Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
- **Severe**: Any unexpected or unintended incident that caused permanent or long-term harm, to one or more persons.
- **Death**: Any unexpected or unintended incident that caused the death of one or more persons.

The Learning Together Approach looks at six key inter dependencies[11]

[9] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75602
[10] Glossary - Root Cause Analysis NPSA
[11] http://www.scie.org.uk/publications/guides/guide24/concepts/patterns.asp

- **Human–tool operation**: Frameworks for the assessment of need and associated electronic and paper forms are all tools. Instead of being seen as passive objects that help professionals do the same tasks as before but better or faster, they actually alter the nature of the task the human does. It is important, therefore, to find out how people and tools interact.
- **Human management system operation:** Management systems include resourcing issues, performance management and associated indicators, as well as particular styles and content of supervision. They are explicitly designed to influence practice.
- **Communication and collaboration in multi-agency working in response to incidents/crises**: Referral procedures and cultures of feedback In our case reviews, we found that agencies tend to work relatively well together in crises where they are all using the same, well-established guidance in Working Together.
- **Communication and collaboration in multi-agency working in assessment and longer-term work**: Understanding the nature of the task; assessment and planning as one-off event or on-going process and responsibilities of different agencies.
- **Adult at risk–professional interactions**
- **Human judgment/reasoning e.g**. failure to review judgments and plans.

Although acknowledging that there are potential limitations to using chronologies[12], both Learning Together and Root Cause Analysis use version-controlled versions as a means of providing a common context, recording what was known and at what point in a review.

Research suggests that reviews should distinguish between[13]

- Issues with clear cut solutions that can be addressed locally and by all relevant agencies.
- Issues where solutions cannot be precise because competing priorities and inevitable resource constraints mean there are no easy answers.
- Issues that require further research and development in order to find solutions including that would need to be addressed at national level

Hounslow Safeguarding Adult Board acknowledges that the London Branch of the Association of Directors of Adult Social Services has commissioned the development of London wide Safeguarding Adults Review policy and procedure.

In interim the board is intending to operate a review model based on the research described above and learning from work completed in the last two years. Three levels of review will be commissioned.

[12] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013

[13] Fish et al 2009 cited Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013 page 24

1. **Focused Review** to address a specific question within a referral for a safeguarding adults review. This would typically be completed as a desk top review
2. **Medium Level Review** is a whole case review based on a learning together approach facilitated by a senior member of staff drawn from local services
3. **High Level Review** is a whole case review based on a learning together approach facilitated by an externally contracted reviewer.

All other aspect of this policy will remain unchanged until the London wide policy is introduced.

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2. Procedure

The Safeguarding Adults Review subgroup of the Hounslow Safeguarding Adult Board will oversee the commission, progress and reporting of all reviews conducted in the London Borough of Hounslow.

The group will consist of the Hounslow Safeguarding Adult Board representatives of Adult Social Care (chaired by the Director Adult Safeguarding, Social Care and Health), Integrated Care Board and the Metropolitan Police. Other agencies may be invited to attend SAR group meetings with the Chair's agreement. Head of Safeguarding (Adults) and Quality Assurance and board business manager will also attend. The business manager will manage any process associated with the subgroup.

The group will meet on a quarterly basis.

The role of the referrer

Referral to the panel will be made by the agency representative on Hounslow Safeguarding Adult Board. If the agency is not represented on the board the Head of Safeguarding (Adults) and Quality Assurance will submit a referral. A referral will include

- The name date of birth (if known) and address of the adult at risk
- A description of how the situation meets the criteria for a Safeguarding Adults Review or why it is an example of good practice which merits exploration and dissemination of shared learning
- A suggested focus for the review
- A description of why consideration by Hounslow High Risk Panel, Provider Concerns Policy or internal complaints or incidents procedures are not appropriate
- An initial chronology using the template in Appendix 1
- A summary of the communication with the adult at risk, their carers, friends and family: are they aware a Safeguarding Adults Review is being considered?

Referrals should be marked for the attention of the Hounslow Safeguarding adults Board, Business Manager and sent by email to SafeguardingAdults@hounslow.gov.uk. Please note that e-mail should be sent from a secure e-mail account ending in hounslow.gov.uk, nhs.uk or met.pnn.police.uk.

Members of the public can also request a review. For support in submitting a referral please contact the board business manager on 020 8583 3690.

Role of the Safeguarding Adults Review subgroup

The subgroup will determine the level of review required using the decision-making framework below as a guide. Where the review is considered to require a Speed+, Intensive or Full review the chair of the subgroup will liaise with the independent chair of the Hounslow Safeguarding Adult Board.

The Specialist Crime Review Group (SCRG) is responsible for determining who will provide the Metropolitan Police Service (MPS) response to all statutory reviews.

The subgroup will inform the MPS of any considerations of, or commissioning of any statutory SAR by emailing seriouscasereviews@met.police.uk.

The subgroup will:

- Decide the level and type of review required
- Determine the focus of the review
- Agree the timescale within which it is to be completed
- Identify a lead reviewer/agency
- Inform the MPS of any consideration of, or commissioning of a SAR

The chair of the group will confirm all recommendations for review with the chair of the Hounslow Safeguarding Adults Board before a decision is communicated to the referrer. The chair of the Hounslow Safeguarding Adults Board will sign off the completed SAR agreement template, included at Appendix 1.

On completion of the review the subgroup will be responsible for ensuring

- Agreed recommendations are implemented.
- Following actions that may have become apparent during the review are put into effect.
- Coordinating enquiries made to the Hounslow Safeguarding Adults Board.

Funding the review

The statutory member of the board (the police, local authority and integrated care board) will ensure that the resources of funding necessary to complete the review is in place.

The burden for funding an individual review will normally fall to the agency with primary responsibility for the episode of care in which the incident that prompted the review arose. It is accepted that an issue or issues prompting the review may often fall across several agencies. In this instance agencies will share financial responsibility.

Role of the review lead

The identified review lead will complete (or ensure that they are completed) the following appendices in a way that is proportionate to the type of review commissioned.

- Additional chronologies (as shown in appendix 2) as required
- Complete a draft review plan using Appendix 3
- In the event that the review takes longer than three months, complete the review update report shown in Appendix 4
- Complete a draft review report shown in figure 5

The identified lead should

- Identify the key professionals involved in the review
- Plan communication with the adult at risk their carers, friends and family.
- Arrange a meeting of the key professionals to agree the terms of reference required to address the review focus
- Send a completed review plan to the Head of Safeguarding (adults) and Quality Assurance.
- Complete the review as planned
- For a medium or high level review the review will include a workshop to review the evidence collated during the review and formulate recommendations. The purpose of the workshop is to ensure that all relevant recommendations have been identified and are practical and achievable. The review author should distinguish between:

    - Issues with clear cut solutions that can be addressed locally and by all relevant agencies.
    - Issues where solutions cannot be precise because competing priorities and inevitable resource constraints mean there are no easy answers.
    - Issues that require further research and development in order to find solutions including those that would need to be addressed at national level.
- Send a draft copy of the review report to the Head of Safeguarding (adults) and Quality Assurance.
- Report submitted to the Safeguarding Adults Review Sub-Group.

Communication with adult at risk their carers, friends and family

Particular care needs to be taken when communicating with the adult at risk, their carers, friends and family. Care should be taken to identify whether they have the decision-making capacity[14] to participate. If the adult at risk lacks capacity care should be taken to tailor communication to facilitate their involvement.

The review team should determine who the best person to approach the adult at risk is. This may be the review led or someone else within the review team. The discussion with the adult at risk should include, but not be limited to:

- Explaining why, or revisit and explanation given prior to referral, a review is being undertaken
- Ask how they want to be involved?
    - Do they want to be involved in discussions about what happened?
    - Do they want to be seen alone or with others?
    - Do they need support to contribute?
    - Do they want to be involved in workshops with professionals? How could this be managed
- Ask how they would prefer communication to be maintained
    - Would they prefer a consistent person to act as point of reference?
    - Would they prefer communication in writing?
    - Do they want to nominate a person to act as their representative?
    - Do they have any specific communication needs?
- Whether they want to have the review conclusions should be shared with them.

The involvement of carers, friends and family should be mapped (were possible with the adult at risk) to determine who needs to be involved in the review. The communication planning process shown above should be repeated.

Communication with professionals and staff

[14] Mental Capacity Act 2005

The purpose of a review is to identify learning; however, it may identify issues that need to be addressed by employers, professional bodies or regulators. Care needs to be taken that a proportionate approach to due process is taken. Colleagues should not be offered false reassurance[15] that there is "nothing to worry about".

Research[16] suggests that personal contact with colleagues should be made to explain why the review is taking place. For a Themed, Focused or Mid-Range review it may be appropriate to offer informal or group explanations. A Speed+, Intensive or Full review will require a personal explanation followed by a letter confirming why the review is being completed, how they will be involved and the support available.

Communication with the public

The Safeguarding Adults Review subgroup will manage all public communication with the assistance of relevant agency communication teams.

Quality assurance

The Head of Safeguarding (adults) and Quality Assurance will either offer or facilitate support and where appropriate task specific supervision for the review lead.

An approval process for the review to proceed will be completed at the point that:

- A draft review plan using Appendix 2 is completed with specific attention to the communication plan.
- In the event that the review takes longer than three months, the review update report shown in Appendix 3 is completed.
- A draft review report shown in figure 4 is completed.

The approval process will look at

- Has the review plan taken account of all the relevant key lines of enquiry?
- Are appropriate and proportionate review methods being used?
- Is the communication plan appropriate?
- Is the review report complete, does it outline a sound analysis, is it clear and written in plain English?

The Head of Safeguarding (adults) and Quality Assurance will coordinate the quality assurance function of all reviews before presentation to the board sub-group for ratification.

Policy Review

[15] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013

[16] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together System model: lessons learned from the pilots. Munro ER & Lushey C, CWRC Working paper No17 March 2013

The Safeguarding Adults Review sub-group will review this policy on the publication of the London wide procedure or in December 2018, whichever event is sooner.

Appendix 1 - Chair's SAR Agreement Template

1. Case ID:

2. Meets Care Act S44 Criteria:

Does this case meet Section 44 of the Care Act 2014?		
1	Does the case involve an adult with care and support needs (whether or not the local authority has been meeting any of those needs)	Yes/No/ *If yes go to 2. If no not a SAR*
2	Is that adult's ordinary residence in Hounslow?	Yes/No/ *If yes go to 3. If no not a SAR*
3	Is there reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult	Yes/No *If yes go to 4. If no not a SAR*
4	Has the adult died AND does the SAB know 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	Yes/No/ *If yes, this case must be subject to a review. If no go to 5*
5	Is the adult still alive AND does the SAB know or suspect that the adult has experienced serious abuse or neglect.	Yes/No *If yes, this case must be subject to a review. If no to 4 and 5 review not required although 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.*

3. Date SAR Group met:

4. Agreed actions:

The case summary is attached to this agreement for information.

Level of SAR recommended:

Chair of Safeguarding Adults Board approval (delete as appropriate): YES/NO

Signed _____ Date: _____

APPENDIX 2. – Chronology Format

Version [number], DD/MM/YY [time - 24-hour clock] [completed by]			
Date	Time	Source of information	Event
DD/MM/YY	01.20	e.g. Clinical notes	
DD/MM/YY	02.30	e.g. interview with X	
DD/MM/YY	15.30	e.g MERLIN report	

APPENDIX 3

Review plan

Rational for review – to be provided by the Safeguarding Adults Review Sub-Group of the Hounslow Safeguarding Adults Board

- Issue identified
- How does the issue identified meet the policy criteria for review

Process

1. Consultation, as appropriate with the adult at risk, their partner and family.
2. A letter signed by the chair of the SAB, where appropriate, sent to the relevant organisation or people identified in case review
3. The review lead to identify
    a. Potential resources (including potential contributors to the review, administrative and other resources)
    b. Records and people that reviews may need to access
    c. Draft terms of reference
4. The review lead is to ensure the following steps are completed.
    a. Determine how and by whom the adult at risk, their partner and family are involved. Identify the person who will maintain contact with the people identified
    b. People required for review who can
        i. Review the evidence
        ii. Review the professional contributions required
        iii. Identify any other specialist contributions required
        iv. The administrative support required
    c. Agree how relevant records, staff and other people involved in the review will be accessed
    d. Determine who will provide the resources required for the review
    e. Agree a project plan specifying when and by whom tasks will be completed
    f. Identify a project manager for the review
5. Fact finding phase of the review to be completed.
6. The Safeguarding Adults Review Sub-Group to review the fact-finding phase of the case review to establish whether the following reports are of a satisfactory standard. This will include -
    a. A summary of the evidence including a timeline
    b. Specialist reports
    c. Any other evidence that has been identified during the fact-finding phase
    d. If appropriate initial recommendations
    e. The Safeguarding Adults Review Sub-Group will determine
        i. Whether further work is required
        ii. Whether a group of the professionals involved should be convened to review the evidence and make recommendations

7. Convene a meeting of the professional involved in the issue being reviewed to determine recommendations.
8. Ensure that the final report (appendix 4) is completed.

Appendix 4 – Update report for submission to the Safeguarding Adult Review subgroup of the Hounslow Adult Safeguarding Adults Board

Review [name] **Review lead/project manager** [name] [date]

Review plan action and date by which it is to be achieved	Intended outcome	Progress to date	Issues to be addressed by Safeguarding Adults Review Group	Safeguarding Adults Review Group comments

APPENDIX 5 – Safeguarding Adults Review, Report format

1. Report format

1.1. The final report will be circulated electronically. People with a visual or auditory will be able to use a reader that that works with the Word format shown in this section of the terms of reference.
  1.1.1. The report should be typed in Arial 12
  1.1.2. Be typed in black
  1.1.3. Using the Word format shown in this section of this report so that it is compatible with electronic readers
1.2. Each version of the report should be version controlled in the header section of the report. The version control should
  1.2.1. State the initial of the person to whom the case review refers
  1.2.2. The name of the person completing the report
  1.2.3. The date on which the current version was completed
  1.2.4. The version number of the report
1.3. The report should be presented in the format shown below

SAFEGUARDING ADULT REVIEW
CONCERNING
[Name of person]

OVERVIEW REPORT FOR
HOUNSLOW SAFEGUARDING ADULTS BOARD

[Name of author]

[Date of report]

CONTENTS

EXECUTIVE SUMMARY

1. **INTRODUCTION**

2. THE CIRCUMSTANCES THAT LED TO A SAFEGUARDING ADULT REVIEW BEING UNDERTAKEN IN THIS CASE

3. VIEWS OF THE ADULT AT RISK

4. TERMS OF REFERENCE

5. PROCESS OF THE SAFEGUARDING ADULTS REVIEW

6. FACTS OF THE CASE

Version [ ], DD/MM/YY time [completed by]			
Date	Time	Source of information	Event
DD/MM/YY	01.20	e.g. Clinical notes	
DD/MM/YY	02.30	e.g. interview with X	
DD/MM/YY	15.30	e.g MERLIN report	

7. ANALYSIS OF THE CASE

8. TRAINING NEEDS (IF ANY)

9. **GENERAL CONCLUSION**

10. RECOMMENDATIONS

11. References