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

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Safeguarding Adults Review Procedure

1. Introduction

1.1 This document should be read in conjunction with the London Multi-Agency Adult Safeguarding Policy and Procedures 2019[1], the Care Act 2014[2] and the Care and Support Statutory Guidance[3] accompanying the Care Act.

1.2 Section 44 of the Care Act 2014 requires that Safeguarding Adult Boards (SABs) are responsible for Safeguarding Adult Reviews (SARs). Paragraphs 14.162 to 14.179 of the Care and Support Statutory Guidance set out in more detail the principles, definitions and a framework for when certain events should happen.

1.3 SABs must arrange a SAR when an adult with care and support needs in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

1.4 A SAB has discretion to arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

1.5 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.

1.6 The Care Act 2014 requires SAB member agencies to cooperate with and contribute to the carrying out of a SAR.

1.7 This SAR Procedure has been developed by the Haringey Safeguarding Adults Board (HSAB) to support effective identification of and response to SARs and to support the Board in discharging its statutory duty.

1.8 The Procedure describes the process to follow and is informed by the Care Act 2014 and Statutory Guidance and the London Multi-Agency Adult Safeguarding Policy and Procedures 2019 (see section 2.9).

1.9 In addition to this Procedure, the Social Care Institute for Excellence (SCIE) SAR Quality Markers[4] (March 2022) in Appendix A provide a useful checklist to support the commissioning and conduct of high-quality SARs.

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[1] https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures/

[2] https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

[3] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[4] First published in Great Britain in June 2018 by the Social Care Institute for Excellence © SCIE & RiPfA 2018 (Written by Sheila Fish). Updated March 2022.

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. SARs are not an enquiry into how a vulnerable adult died nor are they to apportion blame. SARs are conducted to learn from such situations to prevent similar harm occurring again.

2.2 The purpose of a SAR 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 SARs are not an alternative to a safeguarding enquiry, investigation or process.

2.4 The purpose of conducting a SAR is to:

- Learn from the way local agencies, staff and volunteers worked together to safeguard adults at risk, both what did and did not work well.
- Agree how this learning will be acted on, and what is expected to change as a result.
- Review the effectiveness of multi or single agency policies and procedures.
- Inform and improve local inter-agency practice.
- Provide an overview report that brings together and analyses the findings of the various reports from agencies to make recommendations for future action.

2.5 SARs are not disciplinary proceedings; they should be conducted in a manner which facilitates learning and should make appropriate arrangements to support staff involved with the case. If there are issues of performance and/or discipline which need to be addressed arising from the SAR, then these must be dealt with within each agency's normal procedures.

2.6 It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents. Agencies may also have their own mechanisms for reflective practice. This Procedure is not intended to duplicate or replace these, but it remains a statutory requirement in its own right and will be complemented by other such processes.

3. Criteria for Safeguarding Adults Reviews

3.1. **Mandatory SAR criteria:** 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.

3.2. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention or has suffered permanent harm or had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. Where the criteria in 3.1 are met, the SAB is under an absolute duty to conduct a SAR.

3.3. **Discretionary SAR criteria:** The SAB may also consider a SAR on a discretionary basis for any other case involving an adult with needs for care and support that does not meet the mandatory criteria, for example:

- A case that can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice.
- A case involving adult(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review.

3.4. The Care and Support Statutory Guidance identifies different types and patterns of abuse and neglect, including the following:

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

3.5. In deciding whether a SAR should be conducted, the SAB must first consider whether the mandatory criteria to undertake a SAR are met. If the mandatory criteria are met, the SAB is under an absolute duty to conduct a SAR. If not met, the SAB should consider whether commissioning a discretionary SAR would be a valuable exercise, that is, whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focused on those cases that will yield the greatest learning and practice development.

4. Referral of Cases for a Safeguarding Adults Review

4.1. Any agency, professional or member of the public may consider that a case meets the criteria for a SAR and request that one be undertaken by the Haringey Safeguarding Adults Board (HSAB) by completing the SAR Referral Form at Appendix B.

4.2. The referrer is encouraged, where possible, to discuss the concern with their agency safeguarding lead and/or line manager to ensure that the SAR criteria in Section 3 above is fully considered before making any referral.

4.3. It is important to note the HSAB will only consider cases "in its area" as per Section 44 of The Care Act 2014. In practice this means it will consider cases which relate to people residing within the borough of Haringey (which includes people who have been placed by other local authorities or Clinical Commissioning Groups into the area). Should a person placed by Haringey in another area be the subject of a SAR, then it would be for the SAB of that locality to carry out and oversee a SAR.

4.4. The formal SAR referral should be made to the Independent Chair of the HSAB, and should include details of the case, agencies involved and reasons for making the referral. The referral should be made in a timely way and explanations given for any delays in submitting referrals shortly after the death or significant incident.

4.5. The HSAB has delegated management of the legal responsibility to commission SARs to the SAR Subgroup, which is also chaired by the Independent Chair of the SAB, and meets quarterly throughout the year. Upon receipt of a SAR referral, the Chair of the SAR Subgroup will review the information against the criteria and will arrange to consider the case at the next SAR Subgroup meeting.

4.6. The SAR Subgroup will consider the referral and discuss the issues in the case. The Subgroup will consider whether or not the request meets the mandatory or discretionary criteria for a SAR.

4.7. In all cases the SAR Subgroup should seek to establish whether the matter is also subject of a police investigation, judicial or coronial investigation. If the case is, the Subgroup should speak to the relevant persons to ensure that it is appropriate for the Board to procced with the SAR at that stage. If a SAR report has been completed without the judicial or coronial process being finalised, the Subgroup should speak to the relevant persons before publishing the report.

4.8. Equally where an issue triggers a mandatory investigation or review within an organisation (e.g. NHS serious incident investigation) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive. In all such cases, legal advice may be appropriate to guide the decision-making.

5. Deciding to Undertake a Safeguarding Adults Review

5.1. The SAR Subgroup remains responsible to the HSAB. The SAR Subgroup has ultimate responsibility for deciding whether or not to conduct a SAR. Based on the information in the SAR referral, the Subgroup will consider and agree if the case meets the mandatory or discretionary SAR criteria.

5.2. If the Subgroup agrees that a SAR should be instigated, the Chair of the Subgroup will highlight the decision at the next SAB meeting and notify all agencies involved about the SAR.

5.3. The decision to proceed (or not) with a SAR should be conducted in a timely manner, and any positive or negative delays to decision-making or initiation of a SAR should be clearly recorded in the minutes of the relevant SAR Subgroup meetings.

5.4. If the decision of the Subgroup is not to proceed to a SAR, the Subgroup may consider whether to recommend to the relevant agency an alternative review or a smaller-scale audit of the agency involvement. In such cases, the Subgroup may request that the agency share their findings with the Subgroup or other appropriate body.

5.5. If the Subgroup decides not to conduct a SAR, the Chair of the SAR Subgroup will write to the person requesting the review explaining the reasons for the decision.

5.6. If the referrer wants to appeal against the decision, it should be put in writing to the Independent Chair of the HSAB, who will discuss and review (if necessary) the decision with the SAR Subgroup members who decided on the initial request.

5.7. The referrer should be notified in writing of the outcome of their appeal. If the appeal is not successful, the referrer should be notified that they can make a complaint to the Local Government and Social Care Ombudsman. Further details can be found: https://www.adass.org.uk/media/4104/cpf-26-150203-safeguarding-adults-boards.pdf

6. Commissioning a Safeguarding Adults Review

6.1. Once it has been agreed to commission a SAR, the most appropriate methodology to use should be considered. Different methodologies will suit different types of circumstances. These can range from facilitated learning events over a day or two, through to formal panel-led overarching enquiries carried out over a period of time.

6.2. In selecting the methodology, the SAR Subgroup should refer to the methodology model in Appendix C. Whatever methodology is used, it must be proportionate to the specific circumstances of the case. It should provide the most effective learning mechanism and best enable the involvement of key agencies and staff as well as those who are connected to the person (e.g. family etc.) and achieve the outcome required.

6.3. Haringey Safeguarding Adults Board will be the only body which commissions a SAR relating to the abuse and/or neglect of an adult in Haringey. The Care and Support Statutory guidance indicates that, whichever methodology is employed, the following elements should feature in a SAR:

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

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

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

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

D. **Early discussions with the adult and their family/carers** to explain the purpose and process of the SAR, agree to what extent, how they wish to be involved and to manage expectations. This includes access to independent advocacy if required. This process may involve identifying a next-of-kin and appropriate efforts should be made to liaise with the appropriate persons.

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

F. **A final report and recommendations**, which effectively sets out the specific and wider learning considerations.

G. **An action planning session**, to help relevant agencies identify achievable actions to be taken from the report.

H. **A briefing for staff** on key learning points.

6.4. As soon as it has been established and agreed that a SAR should take place, the SAR Subgroup will draft terms of reference for the review to be refined and agreed by the SAR Panel, once established.

6.5. The terms of reference should set out the period on which the SAR will focus; which partner agencies should be involved and those to be part of the SAR Panel; how the adult at risk or relatives, family or friends will be supported and involved in the process; the methodology and timeline for completion (expected to be within 6 months); and the final product that will be produced and how it will be presented to the SAB.

6.6. Once the draft terms of reference are in place, arrangements will be made to set up the SAR Panel to oversee the review. The Independent SAB Chair will notify senior SAB representatives of the relevant agencies about the SAR, request nominations to the SAR Panel and advise that their records relating to the adult at risk must be secured with immediate effect. Members of the SAR Panel should come from the main partnership agencies and have appropriate seniority and experience regarding the case under review. Any specific actions required of the agency in preparation for the SAR will be confirmed with a timescale for completion.

6.7. Where appropriate, the Independent SAB Chair will notify the Care Quality Commission, Police and Coroner's office that a SAR is taking place.

6.8. The Specialist Crime Review Group will be notified at SeriousCaseReviews@met.police.uk when a SAR is commissioned where there is a death including suicide.

7. Conducting a Safeguarding Adults Review

7.1. In the process of conducting a SAR, the SAR Panel will:

- Finalise and agree terms of reference for the review.
- Establish what evidence is required from each agency or person, and how this will be collected (e.g. by individual management review).

- Request further information from agencies as required.
- Consider the facts and circumstances of the case and the evidence received.
- Identify the type of abuse and/or neglect involved in the case.
- Analyse the impact of the person's race, culture, ethnicity and other protected characteristics, as codified by the Equalities Act 2010[5], on the circumstances of the case.
- Identify relevant policy, practice or procedures, nationally and locally, that may be relevant to the conduct of the review.
- Manage the interface between the review and any other investigations or reviews of the same case taking place.
- Take into account the nature and extent of legal advice required.
- 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.
- Agree the key learning points to be included in reports and action plans; and
- Agree the final draft version of the SAR report to be presented to the SAR Subgroup.

7.2. The SAR Panel should consider how the SAR process will dovetail with any other relevant reviews or investigations that are running in parallel, such as a child Serious Case Review (SCR) or Domestic Homicide Review (DHR), a criminal investigation or a Coroner's inquest. It may be helpful when running a SAR alongside another review to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication.

7.3. 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.

7.4. The SAR Panel should also consider how the adult at risk and/or their family/ representative, can be involved in the process and kept informed on its progress. In accordance with the Care Act 2014, where an adult has difficulty in participating, this should involve representation and support from an independent advocate. 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.

7.5. All SAR Panel members should be made aware that the documents and information they are handling during the course of the SAR is highly sensitive and should not be disclosed to anyone.

7.6. Under Section 45 of the Care Act, organisations have a duty to disclose information requested by the Board for the purposes of a SAR. Any agencies that refuse to comply with information requests should be reminded of their duties under the Care Act.

7.7. The documentation submitted to and produced by the SAR Panel is owned by the Haringey Safeguarding Adults Board (SAB) for the purpose of a SAR and is therefore not subject to the Freedom of Information (FOI) Act 2000. SABs are separate statutory bodies in their own right and are not subject to FOI requests. The exclusion of SABs from the Act reflects the important public interest in maintaining the integrity and confidentiality of their investigations and dealings with agencies.

[5] https://www.legislation.gov.uk/ukpga/2010/15/contents

7.8. Each Safeguarding Adults Review should take a whole systems approach to the analysis of learning within the review, which considers:

- Direct practice with the individual
- Inter-professional and interagency collaboration
- Organisational features affecting how practitioners and teams worked
- SAB leadership, oversight and governance
- The broader legal and policy context.

7.9. The timescale for completion of a SAR is 6 months. If a longer period is needed, this should be proposed and agreed with the Independent SAB Chair. 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 capture the points from the case about improvements needed and take corrective action. It is important that SAR reports comment on whether reasons for any delay were positive, such as waiting for the conclusion of criminal proceedings, or negative, such as agencies failing to cooperate.

8. Safeguarding Adults Review Reports and Recommendations

8.1. The Chair and SAR Panel members are responsible for ensuring the SAR report is drafted and delivered within timescales, and is consistent with the terms of reference. The report should bring together all the relevant information with an analysis of events and should include recommendations for improvement.

8.2. It is important that the SAR report identifies whether the SAR meets the mandatory or discretionary SAR criteria, the type of abuse and/or neglect involved in the case, the rationale for the selected SAR methodology, and the impact of the person's race, culture, ethnicity and other protected characteristics on the circumstances of the case.

8.3. Agencies involved in the SAR should be invited to comment on the factual accuracy of the draft SAR report.

8.4. The SAR Panel should receive and agree the draft report before it is presented to the SAR Subgroup so that panel members are satisfied with the analysis and conclusions, and these have been fully and fairly represented. However, it should be understood the SAR Reviewer should have final editorial oversight. If there are issues arising that are contentious, and full agreement to the final report is an issue, then the SAR Subgroup Chair should be engaged to find an appropriate way forward.

8.5. The SAR Subgroup will be responsible for quality assuring the final SAR report and will use the SAR Quality Markers checklist (see Appendix A) as an aid to help with this process. Final reports will be presented to the SAR Subgroup ahead of any SAB meeting, to consider the issues and resulting recommendations, seeking clarification on any issues as required. The SAR Subgroup will identify whether the report contents are appropriate and identify any potential areas of contention. Any outstanding issues or resolution will be confirmed.

8.6. The final agreed report will then be presented to the next SAB meeting. The SAR Subgroup will make recommendations to the SAB about publication and media and communications strategy. Only when the HSAB agrees the SAR report, it is accepted as final.

9. Publishing a Safeguarding Adults Review Report

9.1. The SAB recognises the importance of transparency and disseminating learning from SARs. The HSAB's default position is to publish the report in full, however, sensitivity to the person and family may affect the decision. The SAB will decide to whom the SAR report, in whole or in part should be made available, and how this will be done. This will usually include publication on the SAB's webpage, which is part of the Council's website.

9.2. The Independent Chair of the SAB will ensure that appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of six years in line with Local Government Association guidance. This can be reviewed if there is an overriding public interest or business need to do so.

9.3. The Care Act 2014 requires the SAB to publish the findings of any SAR in its Annual Report within the legal parameters of confidentiality. It should at least refer to a SAR being completed and how learning will be implemented. Where the SAB decides not to implement an action plan from the findings, it must state the reason for that decision in the Annual Report.

9.4. Any reports to be published must be fully anonymised. In doing so, sensitivity must be given to the wishes and views of any family, relative or the person who is the focus of the SAR about the use of anonymised language. However, if the person subject to the review or their family would like to have them named, then as long as they have understood the full implications of this decision, they may be named.

9.5. All SAR reports should be submitted to the National SAB Chairs' SARs Library within a suitable timeframe once published.

10. Findings, Learning and Implementing Recommendations

10.1. The real value of a SAR is to ensure that relevant learning is understood, the impact considered and addressed through improved working arrangements across services supporting adults at risk and that multi-agency safeguarding practice is improved, in order to do everything possible to prevent the issues in question happening again.

10.2. The SAR Subgroup is responsible for ensuring the development of a SAR Action Plan which fully addresses the report recommendations.

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

10.4. The SAR Subgroup will agree a summary 7-minute briefing that will be disseminated to staff to aid learning from the SAR. HSAB partners will be required to assure the SAR Subgroup that learning from the SAR has been passed on to staff.

10.5. In addition to SARs that are conducted by the HSAB, it will be important to learn from SARs conducted by other SAB areas more generally.

Appendix A: Social Care Institute for Excellence: Safeguarding Adults Review Quality Markers checklist

See separate Appendix.

Appendix B: Safeguarding Adults Review Referral Form

Safeguarding Adults Review (SAR) Referral Form Checklist

Below is a list of questions that you must be able to answer before making a safeguarding adults review (SAR) referral.

1. **Is the person aged 18 or over?**
   The person subject to the SAR referral must be an adult aged 18 or over.

2. **What are/were the person's social care and support needs?**
   The person subject to the SAR referral must have needs for care and support. Care and support needs arise as a result of physical or learning disabilities, mental or physical ill-health, dementia or substance misuse, and are focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and, in some circumstances, accessing a care home or other supported accommodation. The local authority does not have to have been meeting any of these needs for the SAR referral to be made.

3. **Which organisations did not work well together to safeguard the person's needs?**
   There must be reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the person subject to the SAR referral. Where only one organisation is suspected to have failed to safeguard the person's needs, it may be appropriate for a single agency learning review to be undertaken, rather than a SAR.

4. **What is the nature of the suspected abuse or neglect?**
   Where the person has died, what type of abuse or neglect is suspected to have led to the person's death? In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. The Care and Support Statutory Guidance identifies different types and patterns of abuse and neglect, including the following:

   - Physical abuse
   - Domestic violence or abuse
   - Sexual abuse
   - Psychological or emotional abuse
   - Financial or material abuse
   - Modern slavery
   - Discriminatory abuse
   - Organisational or institutional abuse
   - Neglect or acts of omission
   - Self-neglect

5. **What other processes or enquiries are already known to be in progress?**

It is important to give details of any other learning processes or enquiries that you know to be under way in relation to the case, for example, domestic homicide review (DHR), homelessness fatality review (HFR), learning disabilities mortality review (LeDeR), serious incident (SI) review, criminal investigation, Coroner's inquest, etc.

Safeguarding Adults Review (SAR) Referral Form

All Safeguarding Adults Review (SAR) referrals will be considered by the SAR Subgroup in accordance with the Haringey Safeguarding Adults Board's SAR Procedure. A SAR is a process for Haringey Safeguarding Adults Board (HSAB) partner agencies to learn lessons and make improvements, not to apportion blame to individual people or organisations. A SAR is about promoting effective learning and improvement to prevent future deaths or serious harm occurring again.

1. Reason for referral Please indicate which criteria below you believe applies to this case:	
The HSAB must arrange a SAR where - a) An adult with care and support needs* (whether or not those needs are met by the Local Authority) in the HSAB's area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult, or…	☐
b) An adult with care and support needs (whether or not those needs are met by the local authority) in the HSAB's area has not died, but it is known or suspected the adult has experienced serious abuse or neglect** and there is concern the partner agencies could have worked together more effectively to protect the individual.	☐
If the criteria in a) or b) above are not met - c) The HSAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice, or incident(s) or case(s) involving adult(s) at risk of abuse or neglect where it is believed to be in the public interest to conduct such a review.	☐
* Care and support needs arise as a result of a physical or mental impairment and are focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation. ** In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or had reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.	

2. Type/s of abuse present in case (tick more than one if appropriate)			
Physical abuse	☐	Modern slavery	☐
Domestic violence	☐	Discriminatory abuse	☐
Sexual abuse	☐	Organisational abuse	☐
Psychological abuse	☐	Neglect and acts of omission	☐
Financial abuse	☐	Self-neglect	☐

3. Adult's details	
Forename/s:	
Last name:	
Date of birth:	
Date of death (if applicable):	
Age:	
Cause of death (if known):	
Home Address:	
Gender:	
Ethnicity:	
Disability:	
Religion:	

4. Referrer's details				
Your name:				
Your role:				
Agency:				
Email address:				
Name of your manager:				
Manager's email address:				
Have you discussed this referral with your manager?	Yes	☐	No	☐
Date form completed:				

5. Circumstances leading to referral

Please provide a summary of what happened – the events and circumstances that led to this referral; include when and where the event happened, and in what context. Please also provide details of the person's care and support needs.

Please include the reasons why you think these circumstances might meet the criteria above in Section 1 for a Safeguarding Adults Review.

6. Other processes involved Please provide details of any other processes you know to be under way in relation to this case, eg. DHR, HFR, LeDeR, SI review, criminal investigation, coroner's inquest.

7. Other agencies involved Please list any other agencies or services you know to be involved in this case. For example: adult social services, police, health services, fire and rescue service, housing, probation services, ambulance, residential or domiciliary care, nursing homes.

8. Where to send this form

Thank you for taking the time to complete and submit this Safeguarding Adults Review referral form to the Haringey Safeguarding Adults Board. Please send your completed form to:

The Independent Chair, Haringey Safeguarding Adults Board

c/o Rebecca Waggott, Governance & Improvement Officer
Email: rebecca.waggott@haringey.gov.uk
And copied to: Chris Atherton, Head of Quality Assurance and Development and Principal Social Worker
Email: christopher.atherton@haringey.gov.uk

Appendix C: Methodology Model

The SAR Subgroup should consider which of the following methodologies is proportionate to the specific circumstances of the case and will enable the most effective learning. It should also be considered whether a review in rapid time is required. More information can be found at: https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/

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.