Islington Safeguarding Adults Board

Islington appendices to the London safeguarding adults policy and procedure

The Care Act 2014 ("the Care Act") together with Chapter 14 of the Care and Support Statutory Guidance issued under the Care Act, have introduced a clear framework for safeguarding adults. A revised London-wide safeguarding adults policy and procedure was launched in April 2019 which can be found here. This document is supplementary to the London Safeguarding Adults policy.

This document contains additional information and guidance specific to Islington.

Please also refer to the Islington Safeguarding Adults Partnership Board's Constitution and Information sharing policy, which can be found on Islington Council's website.

Appendix A: Local contact details

This appendix only includes contact numbers relevant to the reporting and investigating of abuse. Many more organisations have a role to play in protecting adults.

SOCIAL SERVICES	
Access and Advice Team: This is the first point of contact. This team takes initial details and refers on to the most appropriate team.	**Tel:** 0207 527 2299 **Fax:** 020 7527 5114 **Email**: access.service@islington.gov.uk accessservicesecure@islington.gcsx.gov.uk
Emergency Duty Team Weekdays- 5pm-9am Weekends and Bank Holidays- 24 hours	**Tel:** 0207 226 0992
CHILDREN'S SOCIAL SERVICES	
Referral and Advice Team (Monday to Friday 9am to 5pm)	**Tel:** 020 7527 7400
Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays)	**Tel:** 020 7226 0992
POLICE	
Islington Police Station	**Address:** 2 Tolpuddle Street, N1 0YY Central Switchboard: 0300 123 1212
Community Safety Team/Officer	**Tel:** 020 7421 0174
Useful links http://cms.met.police.uk/met/boroughs/islington/06advice_and_support/community_safety_unit_csu http://content.met.police.uk/Site/reportingcrime	
INSPECTION	
Care Quality Commission	**Address:** Finsbury Tower, 103 – 105 Bunhill Row, London, EC1Y 8TG **Helpline**: 0300 061 6161
DISCLOSURE AND BARRING SERVICE	
For referrals to the **Employment Barring Service**	**Address:** PO Box 110, Liverpool, L69 3JD **Tel:** 0870 90 90 811 **Email**: info@vbs-info.org.uk

Appendix B: Contact details of local and national support organisations

LOCAL	
Islington Victim Support	1 Highbury Crescent, London, N5 1RN Helpline: 0845 303 0990 (24 hours) or 020 7700 6014 vs.islington@vslondon.org www.vslondon.org
Independent Mental Capacity Advocate (IMCA) Advocacy Partners	0845 0175198
LOCAL (domestic violence)	
Home Safe (children & families)	020 7527 5778
Independent Domestic Violence Advocacy Service (for professionals only 10-4 Mon –Fri)	020 7281 9284
Women's Aid advice and support following violence	0808 2000 247 020 8269 2121
Single Homeless Project	Referral line: 020 7520 8660 Client support line: 0800 783 8993
Criminal Injuries Compensation Authority (CICA)	www.cica.gov.uk Claims: 0300 003 3601 020 7842 6800
Women's Therapy Centre (individual & group psychotherapy)	020 7263 6200 020 7263 7860
Women's Alcohol Centre	020 7226 4581
NATIONAL (for victims)	
Criminal Injuries Compensation Authority	0800 358 3601

Women's Aid Domestic Violence Helpline (24 hour)	0808 2000247
Men's Advice Line & Enquiries	0808 801 0327
Rights of Women (family law advice line)	020 7251 6577
Samaritans www.samaritans.org	0845 790 9090
NATIONAL (for agencies)	
Homeless Link (hostel advice to agencies)	020 7840 4430
Forced Marriage Unit British Nationals	020 7008 0151
NATIONAL (for people causing harm)	
Respect Help for perpetrators of domestic violence	0808 801 0327
Respond For victims or perpetrators of sexual abuse & other trauma, who have learning disabilities.	Helpline: 0808 808 0700
NATIONAL (for agencies and victims)	
Modern Slavery Helpline For advice to professionals and victims who have been force to work illegally against their will in any sector, including brothels, cannabis farms, nail bars, agriculture and domestic servitude.	**0800 0121 700**

Sources of Advocacy

There are many sources of advocacy, both formal and informal.

Informal advocacy is when a friend or family member supports the adult at risk through the safeguarding process. The adult at risk should be offered, and reminded at various stages throughout the safeguarding process, of their right to bring a friend or family member to meetings or to advocate on their behalf. However, it is never appropriate for the alleged perpetrator of abuse to act as an advocate for the adult at risk during a safeguarding investigation.

Formal advocacy is where someone in their professional capacity provides support to an adult at risk. Formal advocacy can be beneficial because the advocate is more likely to be familiar with safeguarding processes and have experience in helping adults at risk say what they want and represent their interests.

Trained advocates are likely to be more useful than untrained ones. But, if the adult at risk has the capacity to choose an advocate, an advocate from an organisation familiar to them might also be appropriate.

Sources of trained advocates in Islington:

Organisation	Services	Contact
PohWer	IMCA, IMHA, advocacy, RPRs	Telephone: 0300 456 2370 Email: pohwer@pohwer.net Website: https://www.pohwer.net/
Solace Women's Aid	Domestic and sexual violence advocacy service	Tel: 020 7281 9284 Email: advocacy@solacewomensaid.org Website: http://www.solacewomensaid.org
Arachne Greek Cypriot Women's Group	Advocacy and interpreters for Greek and Greek Cypriot women	Tel: 0207263 6336 Email: info@arachne-group.org Website: http://arachne-group.org
Carila Latin American Welfare Group	Advice, interpretation and advocacy for the Latin American community in London	Freephone: 0808 800 0540 Tel: 020 7561 1931 Email: carila@carila.org.uk
Deaf Positives	IMHA and Advocacy for Deaf and DeafBlind people	Tel: 01753 551 462 Email: info@deafpositives.org Website: http://www.deafpositives.org
Diabetes UK Advocacy Service	Advocacy prioritised for vulnerable people with diabetes	Tel: 0207 424 1840 Email: advocacy@diabetes.org.uk Website: http://www.diabetes.org.uk

Disability Action in Islington	Advocacy service, advice and information for disabled people. Run by and for disabled people.	Tel: 0207 226 0137 Email: info@daii.org Website: http://www.daii.org
Disability Law Service	Free legal advice and representation.	Tel: 0207 791 9800 Email: advice@dls.org.uk Website: http://www.dls.org.uk
Elfrida Society	Siren Advocacy scheme for people with learning difficulties	Tel: 0207 359 7443 Email: elfrida@elfrida.com Website: http://www.elfrida.com
Family Support Centre 404	Advocacy to parents of children with a disability/special needs and parents of an adult with learning difficulties	Tel: 0207 697 1325 Email: family@centre404.org.uk Website: http://www.centre404.org.uk
Islington Mind	No longer provides an advocacy service, but can refer mental health service users to an advocacy scheme when required	Tel: 020 7561 5289 Email: admin@islingtonmind.org.uk Website: http://www.islingtonmind.org.uk.
Just for Kids	Advice, legal representation and advocacy to young people (ages 10-21).	Tel: 0207 266 7159 Email: info@justforkidslaw.org Website: http://www.justforkidslaw.org
Kith and Kids	2:1 advocacy support for people with learning disabilities and their families	Tel: 020 8801 7432 Email: advocacy@kithandkids.org.uk Website: http://www.kithandkids.org.uk
National Youth Advocacy Service (NYAS)	Advocacy for children and adults with disabilities and mental health advocacy including IMHA's (Independent Mental Health Advocates)	Freephone: 0300 330 3131 Email: help@nyas.net Website: http://nyas.net
POhWER – North London ICAS	Advocacy to support people with NHS complaints	Tel: 0300 456 2370 Email: pohwericas@pohwericas.net Website: http://pohwer.net
The National Autistic Society (NAS)	Advocacy information for people with autistic spectrum disorders and their families	Helpline: 0808 800 4104, Tel: 0207 833 2299 Email: advocacy@nas.org.uk Website: http://www.nas..org.uk
Women at Wish	Advocacy for women in secure services such as Holloway.	Tel: 0208 017 2828 Email: info@womenatwish.org.uk Website: http://www.womenatwish.org.uk

Other organisations that may be able to provide information, advice and support, but not necessarily trained advocates, are:

Action on Elder Abuse	Advice, information and support on elder abuse to adults at risk, their families and whistle-blowers.	Helpline: 0808 808 8141 Tel: 020 8835 9280 Email: enquiries@elderabuse.org.uk Website: http://www.elderabuse.org.uk
Age UK Islington	Advice, information and support to adults aged 55 and over.	Tel: 020 7281 6018 Email: admin@ageukislington.org.uk Website: http://www.ageuk.org.uk
Islington Carers Hub	Information, advice, support and advocacy to carers over age 18	Tel: 0800 085 1141 Email: info@islingtoncarershub.org
Respond	Information, advice and counselling support to adults with learning disabilities who have experienced abuse, sexual abuse or trauma	Tel: 0808 808 0700 Website: www.respond.org.uk/
Victim Support	Help for victims and witnesses of crime	Tel: 0845 30 30 900 Email: supportline@victimsupport.org.uk Website: www.victimsupport.org.uk

Appendix C: Quick guide for alerters

What is 'safeguarding adults'?

'Safeguarding Adults' means making sure that adults at risk live free from abuse and neglect. This used to be called 'Adult Protection'. Everyone working in public services has a legal responsibility to report suspicions or allegations of abuse of adults at risk and children.

Who is an adult at risk?

An 'adult at risk' is someone who is 18 years or over who has needs for care and support (whether or not the local authority is meeting any of those needs).

As a result of their mental or other disability, age or illness, they may find it difficult to protect themselves from abuse. Children can also be at particular risk of abuse and neglect.

What is abuse?

There are many different types of abuse; some examples are:

- Physical
- Sexual
- Emotional/psychological
- Financial/material
- Neglect/acts of omission
- Organisational
- Modern Slavery
- Discriminatory
- Domestic abuse
- Self-neglect

Lots of different people may abuse adults at risk; some examples are:

- People who deliberately target adults at risk
- Members of the adult at risk's own family and friends
- People who are employed to care for adults at risk

Sometimes people are not actually aware that they are abusing someone. Carers of adults at risk may become abusive because they are stressed and tired. It is still important that you report these situations, as Social Services can help to reduce pressure on stressed carers. Carers can also be at risk of harm from the person they care for.

What are the signs of abuse?

There are many signs of abuse – ask if you are not sure! Some examples are:

- The person looks dirty or is not dressed properly
- The person never seems to have money
- The person has an injury that is difficult to explain
- The person seems frightened

There may be other explanations but these are often signs of abuse.

What should I do if I suspect abuse?

- If there is a risk of immediate harm to the adult and/or others:
  - Take yourself out of danger
  - Call 999

- If there is no immediate risk but you think abuse or neglect may be a problem:
  - Call the Islington Access and Advice Service Tel: 020 7527 2299

- If you think another colleague or professional person is abusing an adult at risk:
  - Report this to your line manager.
  - If you are unhappy with their response or do not feel you can approach them then call the Islington Access and Advice Service Tel: 020 7527 2299.
  - You might feel worried about reporting your colleagues. Remember that it is difficult for adults at risk to report abuse and they rely on you to help them.

- If you think a child is at risk, and it is an emergency, call 999.

- If you think a child is at risk, but it is not an emergency, call the Referral and Advice Team (Monday to Friday 9am to 5pm) on 020 7527 7400, or the Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays) on 020 7226 0992.

What happens next?

We will look into your concern.

Depending on what we find, we may take action to safeguard the adult at risk from harm.

Do you suspect abuse? Tell us now.

Islington Adult Access and Advice Service
Tel: 020 7527 2299 | Email: access.service@islington.gov.uk

Appendix D: Raising a safeguarding alert with Adult Social Services

The following is a list of the kinds of questions social services staff may ask when you raise an alert. You do not need to have all this information to hand- we would rather you let us know immediately of safeguarding concerns. This is just to prepare you for the kinds of questions social services staff are likely to ask.

a. Safeguarding Concern

a.i Your name and the name of your organisation

a.ii Your name and contact details (if you are happy to be contacted)

a.iii Name, contact and demographic details of the person you are calling about (if not already on the social services system)

a.iv Where, how and when you found out about the alleged/suspected abuse

a.v Where the alleged abuse is said to have taken place

a.vi Whether the person is an Islington resident

a.vii Whether the person knows you are raising a safeguarding concern

a.viii Whether anyone else knows you are raising a safeguarding concern

a.ix Any actions you or your organisation have taken

a.x Whether the adult is at risk of immediate harm

a.xi Whether there are any other people (children/other vulnerable adults) at risk

a.xii Whether the person has mental capacity to make his or her own safeguarding decisions

b. Suspected Abuse

b.i When the suspected abuse took place

b.ii Details of the suspected abuse – what kind of abuse, how many times it happened and any further details

b.iii Whether the police have been informed

c. Suspected abuser (or person causing harm)

c.i Contact details: name, address, gender, age

c.ii Relationship to the adult at risk

c.iii Whether the person causing harm lives with the adult at risk

c.iv Whether the person causing harm is the adult at risk's main carer

Appendix E: Implementing the Care Act 2014 and Care Act Guidance

The Care Act 2014 came into effect on 1 April 2015. A London-wide safeguarding adults policy and procedure and procedure has recently been updated which can be found here.

To supplement the Care Act, Care and Support Statutory Guidance ("the statutory guidance") and London policy, the Islington Safeguarding Adults Board has adopted these appendices which you are now reading.

Partner organisations

This is a brief guide to implementing the Care Act and the statutory guidance in your organisation, including guidance on circulation, training and developing your own policy and procedure.

Circulation

Please remove any links or references in policies, webpages and intranet pages to:

- No Secrets
- the SCIE London policy and procedure (also referred to as Report 39)
- Previous versions of the Islington Local appendices to the London policy and procedure.

Replace them with references and links to:

- The Care Act 2014
- Care and Support Statutory Guidance
- This version of the Islington Local appendices

Please also notify all relevant staff about the revised London multiagency policy and procedures which were launched in April 2019. Explain to your staff and volunteers the implications for safeguarding adults. You may already have a staff bulletin/newsletter through which you can do this.

You may wish to ask managers of those teams who have close contact with adults at risk to brief team members in person. The briefing might involve explaining the particular role of your organisation, how to make a referral and how staff can be involved in investigations and protection planning.

Training materials

If you run safeguarding adults training events in your organisation, please make sure the content is compliant with the Care Act and the statutory guidance.

For example, you may need to update terminology to be in line with the Care Act if you have not already done so.

- Replace 'safeguarding alert' with the new term 'safeguarding concern'.
- Replace 'safeguarding investigation' with the new term 'safeguarding enquiry or Section 42 enquiry'
- Replace 'serious case review' with the new term 'safeguarding adults review'.

The Care Act has brought more changes than just changes in terminology; it has brought a new way of working. The emphasis is now on making safeguarding personal, that is involving the adult at risk right from the start and helping them achieve their desired outcomes wherever possible.

For a summary of the changes, refer to the Department of Health summary factsheet.

Your organisation's supplement

It is not necessary to replicate the London wide safeguarding adults policy and procedures with your own policy and procedure. What is absolutely necessary is that your staff understand local arrangements for safeguarding adults. You may wish to develop a brief supplement containing local details not given in the London policy and procedure or these appendices.

Your local policy supplement should:

- Be clearly signed off by senior management, so that staff and volunteers know they must follow it.
- Include a clear statement about not tolerating abuse of adults at risk in your organisation
- Refer and link to the Care Act and the statutory guidance, these Islington appendices and the London policy and procedures
- State that your organisation has a legal responsibility to safeguard adults from harm in line with the Care Act and is committed to the principles and definitions set out in the statutory guidance
- Set out the 10 categories of abuse
- Set out different roles and responsibilities: executive team, designated safeguarding adults manager (DSAM), human resources, training department, managers, staff and volunteers.
- Set out what a member of staff should do on hearing or seeing possible abuse, who to contact and the contact details.
- Set out how staff and volunteers may be involved in safeguarding enquiries and safeguarding actions.

- Set out how the organisation will monitor how well staff and volunteers have responded to abuse and neglect. In particular, how you will find out whether your action has led to good outcomes.
- Be clear and easy to follow.

Making sure your staff are following the policy and procedure

You may wish to follow up to see what effect the new policy and procedure has had on practice in your organisation. For example, you might look at records for various safeguarding adults alerts and check whether the alerting and referring procedure has been followed.

Further help and information

For further help and information on implementing the policy and procedure, please contact the safeguarding adults unit:

Email: safeguardingadults@islington.gov.uk
Telephone: 020 7527 2173
Website: www.islington.gov.uk/safeguardingadults

Please remember that if you need to raise an alert about a specific adult at risk, contact the Islington Adult Social Services Access and Advice Service:

Email: access.service@islington.gov.uk
Telephone: 020 7527 2299

Appendix F: Recognising abuse

Adapted from Paragraph 14.17 of the Care and Support Statutory Guidance

This appendix considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to safeguarding concerns. Abuse or neglect can take many forms and the circumstances of each case should always be considered.

Physical abuse	
Includes assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.	Possible indicators: Black eyes Welt marks Fractures Sprains Dislocations Drowsiness Lacerations Pressure sores Unexplained injuries Scalds/cigarette burns Bruises (especially in well protected areas) Confusion due to over sedation Delays in seeking medical attention Anxiety or fear more evident in the presence of a possible abuser
Domestic violence	
Includes psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.	Possible indicators: Changes in behaviour when around partner or family members, for example adapting behaviour to avoid making the other person angry Jealous or possessive partner Socially isolated, many aspects of person's life controlled by partner/family member Constantly criticised and humiliated by partner in front of others
Sexual abuse	
Includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into	Possible indicators: Changes in behaviour (e.g. more withdrawn, depressed, confused, fearful, agitated) Difficulty in walking or sitting Torn, bloody or stained underclothes Pain or itching in the genital area Bruising or bleeding in external genitalia, vaginal or anal areas Venereal disease

consenting.	Sexualised behaviour
Psychological abuse	
Includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.	Possible indicators: Fear Passivity Confusion Wandering Depression Withdrawal Running away Low self-esteem Mental anguish/anxiety Loss of independence Behaviour which is out of character Uncontrolled/unprovoked crying Unusual weight loss or gain A lock on the outside of room Disturbed sleep pattern A physical environment that does not allow access to other parts of the home
Financial or material abuse	
Includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.	Possible indicators: A "disappearing" pension Homelessness Hypothermia Malnutrition Inadequate clothing Insufficient money to purchase basic necessities Inadequate money to pay bills etc Inadequate heating/lighting Sudden and/or large withdrawal from bank etc Legal documents requiring signature
Modern slavery	
Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.	Possible indicators: Neglected or abused physical appearance Withdrawn Isolated – rarely allowed to travel on their own, seem under the control or influence of others, rarely interact with others or appear unfamiliar with their neighbourhood or where they work Poor living conditions, cramped or overcrowded accommodation and/or living and working at the same address May have no identification documents, have few personal possessions and always wear the same clothes Restricted freedom of movement, may have

	had their travel documents retained.
Discriminatory abuse	
Includes forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.	Possible indicators: Unable to eat culturally acceptable foods, Religious observances not encouraged or anticipated Isolation due to language or communication barriers Public humiliation such as taunts from strangers
Organisational abuse	
Includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.	Possible indicators: Poor management of life in the living environment Poor standards of cleanliness Low staffing levels over a long period of time Low staff morale High staff turnover Lack of knowledge about care guidelines; staff factions: Lack of positive communication with residents Punitive treatment of residents/patients Staff ordering residents around Low level/absence of staff training
Neglect and acts of omission	
Includes ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.	Possible indicators: Dehydration Malnutrition Infections Hypothermia Inadequate clothing Pressure sores Unexplained failure to respond to prescribed medication
Self-neglect	
This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.	Possible indicators: Poor personal hygiene, dehydration, malnutrition, untreated or poorly attended medical conditions, hazardous or unsafe living conditions, arrangements, inappropriate clothing.

Appendix G: Interviewing adults at risk (and their possible reactions)

1. This practice note gives some guidance on interviewing adults at risk and some of the common reactions to abuse. Interviewing is often a complex task requiring careful planning beforehand. In many cases an adult at risk will have limited communication and understanding.

2. Points to note before interviewing: -
   - Avoid reaching conclusions about the suspected abuse before the facts are known
   - Consult with an IMCA if appointed or independent advocate arranged by the local authority under Section 68 of the Care Act.
   - Ensure that any communication difficulties are recognised prior to the interview.
   - The location of the interview must ensure privacy, safety and lack of interruption
   - Allow time, remain calm, unhurried and non-accusatory
   - Be clear about confidentiality and explain that information will only be shared on a "need to know" basis explaining also what that means
   - Be aware of not making stereotypical judgements about race, gender sexuality and disability
   - Informing the interviewee the purpose of interview - think beforehand about how you will explain why you are there. It is important not to alarm the interviewee and to establish rapport first. You may initially want to indicate general concern, rather than explain an allegation of abuse has been made
   - Encourage the person to talk (free narrative). If you need specific information, use open-ended questions without leading the person towards a particular response. This should invite more detailed, spontaneous responses.
   - Take account of background information: family history and dynamics, assessment of level of dependency, assessment of needs of carers, what services are being provided, physical and material environment.
   - When closing the interview, summarise what you understand they have said and invite them to ask you questions. Ensure that they are thanked for this, and you can recognise it may have been a difficult experience for them. Let them know what will happen next and who they can contact if concerned about something later on.

3. Victims of abuse do not always react in the same way. However, some of the more common reactions are as follows:
   - Denial that anything is wrong and even an emphasis that all is extremely well
   - Acceptance or resignation of their situation as part of being old and/or disabled
   - Withdrawal from normal activities through a continuum to a total lack of communication
   - Depression which can either happen very suddenly or gradually emerge
   - A dramatic change of behaviour/personality: this can happen very suddenly and unexpectedly and is often associated with fear. This may indicate an attempt at self-protection
   - Physical or verbal outbursts or displays of anger that are out of character
   - Confusion: this can be characterised by a sudden onset or a marked deterioration in a previously confused person
   - Seeking help from numerous sources. This may be a direct request for help or attention seeking behaviour.

Appendix H: Cross boundary and inter-authority safeguarding adults enquiries

Risks may be increased by complicated cross-boundary arrangement and it may be dangerous and unproductive for organisations to delay action due to disagreements over responsibilities. The rule for managing safeguarding enquiries is that the Local Authority for the area where the abuse occurred has the responsibility to carry out the duties under Section 42 Care Act 2014, but there should be close liaison with the placing authority.

The 'placing Local Authority' continues to hold responsibility for commissioning and funding a placement. However, many people at risk live in residential settings outside the area of the placing authority. In addition, a safeguarding incident might occur during a short-term health or social care stay, or on a trip, requiring police action in that area or immediate steps to protect the person while they are in that area.

The initial lead in response to a safeguarding concern should always be taken by the Local Authority for the area where the incident occurred. This might include taking immediate action to ensure the safety of the person or arranging an early discussion with the police when a criminal offence is suspected. Additional guidance on responding to safeguarding concerns which involve cross-boundary considerations can be found here.

Further actions should then be taken in line with Making Safeguarding Personal on the views of the adult, and the Care and Support statutory guidance on who is best placed to lead on an enquiry.

For further information, refer to

1) Section 39 of the Care Act,
2) The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014
3) The Care and Support (Cross-Border Placements and Business Failure :Temporary Duty)(Dispute Resolution) Regulations 2014
4) The Care and Support Continuity of Care) Regulations 2014
5) Care and Support Statutory Guidance, in particular chapters 19, 20 and 21.
6) SCIE Cross Borough Protocol for London, Good Practice Guide

Appendix I: Safeguarding Adults Review Protocol (containing sub-appendices 1-6)

1. Introduction

1.1 The Islington Safeguarding Adults Partnership wants to learn how it can better help adults at risk stay safe from harm. The partnership has agreed the following protocol, so that it can learn from cases where adults at risk suffered as a result of serious abuse and/or neglect.

1.2 All Safeguarding Adults Reviews (SARs) in Islington will have regard to the experience and views of the adult at risk (or representative), and consider how these were sought and taken into account by the professionals involved.

1.3 This protocol draws on the Care Act 2014, the Care and Support Statutory Guidance, Department of Health, ADASS and SCIE guidance and standards (please see the section called 'Sources' for further details). This protocol also draws on national and local experience of conducting SCRs.

1.4 Appendix 6 contains a flowchart which can be referred to for an overview of the whole process.

2. The purpose of Safeguarding Adults Review

2.1 The purpose of a Safeguarding Adults Review is **not** an enquiry into how the death or serious incident happened. Neither is the purpose to find somebody to 'blame'. Such matters will be dealt with by the Coroner's or criminal courts, or other bodies.

2.2 Section 44(5) of the Care Act states each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to:

- Identifying the lessons to be learned from an adults case and
- Applying those lessons to future case

2.3 The purpose of a SAR is set out in Chapter 14 of the Care and Support statutory guidance. It is to:

- Promote effective learning (both what did and did not work well);
- Agree improvement action to prevent future deaths or serious harm occurring again.

2.4 The purpose of an SAR is not to hold any individual or organisation to account. The emphasis should be on learning; not blaming. Other processes exist for that propose, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation such as CQC, the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.

2.5 The desired outcome of a SAR is that:

- Through improved inter-agency working, adults at risk are better safeguarded from serious abuse or neglect
- identify any issues for multi or single agency policies and procedures; and,
- publish a summary report, which is available to the public.

3. Requests for Safeguarding Adults Reviews

3.1 The Care Act 2014 sets out the circumstances in which SAB must consider holding a SAR. The Safeguarding Adults Review Subgroup of the Islington Safeguarding Adults Board (ISAB) will be the only body which commissions an SAR relating to the abuse and/or neglect of an adult at risk in Islington. The subgroup has agreed Terms of Reference that include commissioning SARs.

3.2. All agencies/individuals submitting cases for consideration will be expected to comply with the Confidentiality Agreement (please see Appendix 5).

3.3. The SAR Subgroup will decide whether or not to accept the request for a SAR. The subgroup will make their decision based on the criteria set out in this protocol. The chair of the board and the statutory director will be advised of the decision as soon as possible. The decision will also be reported to the board at the next available opportunity.

3.4. Members of the SAR Subgroup may also request that a SAR is held. The SAR Subgroup will consider these requests, and in consultation with the chair of the board and the statutory director, decide whether to hold a SAR.

4. Criteria (and other factors) for a Safeguarding Adults Review

4.1 The key principles in deciding whether to conduct a Safeguarding Adults Review are set out in the Care Act statutory guidance. Section 44 of the Care Act sets out the circumstances in which the ISAB must carry out a review.

> The ISAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that ISAB partner organisations or other relevant people could have worked more effectively to protect the adult.
>
> The ISAB must also arrange a SAR if an adult in its area has not died, but the ISAB knows or suspects that the adult has experienced serious abuse or neglect.

4.2 The ISAB may also carry out a SAR of any other case involving an adult in the Islington area with needs for care and support.

4.3 When deciding whether or not to hold a SAR, the subgroup will also consider:

- What are the views of the adult(s) at risk, where possible, or their appropriate representative(s) – are they content for a review to be held?
- Was there clear evidence of risk or significant harm which was not recognised by agencies in contact with the adult at risk or person alleged to have caused harm, or not shared with others or not acted upon appropriately?
- Did the abuse occur in an institutional setting?
- Does one or more agency feel that it had significant concerns and these were not taken seriously or acted upon by another?
- Does the case indicate there are failings in the formal safeguarding procedures that go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that there might need to be a change in local protocols or procedures, or that protocols and procedures are not being adequately acted upon?

4.4 Individual agencies may have internal procedures to review cases. This protocol is not intended to duplicate or replace these. A SAR would be used to learn lessons beyond the scope of internal procedures.

4.5 The subgroup will take into account investigations and other types of review which may be planned or already underway. Local and regional liaison may be needed to decide the best way different roles and purposes can be addressed. Legal advice will be sought.

4.6 There are also statutory frameworks for reviews, which would need to be taken account when deciding whether or not to hold a SAR. Again, legal advice would be sought. Statutory frameworks apply in the following circumstances:

- death or serious incidents involving a child or adult;
- homicide, suicide and related serious mental health incidents;
- domestic homicide or suicide involving a person over the age of 16 from violence, abuse or neglect by a relation or member of the same household;
- serious further offences committed by offenders subject to supervision by the Probation Service; and
- work- related deaths, but not arising from clinical judgement or treatment.

4.7 Various regulatory bodies are empowered to carry out investigations of serious incidents. The Secretary of State can direct statutory organisations to conduct investigations, or approve public inquiries recommended by the Health and Safety Executive.

4.8 The approach to the review will reflect locally agreed arrangements on the implementation of best practice guidance and in line with the Care Act Guidance.

These guidelines are designed to secure an integrated approach of which consideration of a serious case review forms a part.

4.9 There may be grounds for one or more reviews – in which case a decision should be made at the outset as to which process is to lead and who is to chair. The potential to do a joint review may be considered to avoid duplication.

4.10 Having considered the criteria and other factors, the subgroup will decide whether to hold a SAR. The decision must have the support of a majority of a quorate meeting. The meeting minutes must record the reasons for the decision, and any minority views.

4.11 The decision should be made not later than one month of receipt of the request and reported as set out above.

5. Actions to be taken once a decision has been made

5.1 Whatever decision is taken, it should be reported to the chair of the board, board and statutory director. All decisions will be recorded in the board's annual review.

5.2 <u>When the subgroup decides to hold a SAR</u>
When the subgroup decides to hold a review, the chair of the subgroup will immediately notify all agencies involved to make sure all relevant records are secured. The subgroup will also take the actions set out in the following sections, to commission a SAR.

5.3 <u>When the subgroup decides not to hold an SAR</u>
When the subgroup decides not to hold an SAR, in accordance with the thresholds set out in section 4 above, the chair of the subgroup will write to the person requesting the review, explaining the reasons. If the person requesting a review still thinks it should be held, the matter will considered at the next full meeting of the board. The decision of the board will be final.

5.4 Where the threshold for a SAR has not been met, the subgroup may recommend that an individual agency (or agencies) review an incident. Often, the agency will be asked to use its own internal investigation procedures to conduct this. For example, an NHS organisation may be asked to use its 'Serious Incident' procedure.

5.5 These reviews should be completed promptly and the findings of fact, learning and need for action shared with the SAR Sub group who will advise the board on any issues requiring further board consideration.

6. Commissioning a Safeguarding Adults Review

6.1 The Safeguarding Adults Review Subgroup will commission SARs. This includes:

- drafting terms of reference for the SAR, the SAR Panel and the SAR Panel Chair;

- appointing the SAR Panel and the SAR Panel Chair (the panel chair may be an independent person appointed on terms agreed with the statutory director);
- making sure resources are available for the review;
- setting timescales within which the review should be completed;
- securing any legal advice required, in particular the Care Act, the Data Protection Act 2018, the Freedom of Information 2000 and the Human Rights Act 1998;
- making sure that all agencies are bound by the Confidentiality Agreement for SAR's (please see Appendix 5);
- managing the interface between the review and other investigations or reviews of the same case that may be taking place; and
- agreeing arrangements for administrative and professional support.

6.2 Appendix 2 sets out questions the SAR Subgroup may consider when commissioning a SAR. The questions are not prescriptive and the particular circumstances of the case under review should be taken into account.

6.3 The Chair of the SAR Subgroup will notify the Care Quality Commission, Police and the Coroner's Office that a SAR is taking place.

6.4 Where appropriate, the subgroup will appoint a named 'liaison officer' who will keep the adult at risk, their family and/or friends, informed of developments relating to the SAR process. This officer will keep in close contact with the police family liaison officer, to make sure that communication is consistent.

6.5 The subgroup will agree and set out the media/communications strategy. The chair and the vice chair of the board will be advised along with the statutory director.

7. Membership of a Safeguarding Adults Review Panel

7.1 Membership of the Safeguarding Adults Review Panel will be made up of people of appropriate standing and experience with regard to the particulars of the case under review. The chair of the SAR Subgroup will write to the chief officers of agencies requesting nominations to the Safeguarding Adults Review Panel.

7.2 Agencies directly involved in the case may not be appropriate members of the SAR Panel.

7.3 The SAR subgroup will not itself undertake reviews but, as long as they have no direct involvement with the case, members of the sub-group may form part of SAR panels.

7.4 It is open for SAR panels to be chaired by an independent person on the recommendation of the SAR Subgroup to the chair of the board and the statutory director. If agreed, the terms of appointment would be agreed with the statutory director. This arrangement may be particularly relevant where there has been extensive agency involvement or where particular public or professional concern suggests this would be appropriate.

7.5 The SAR subgroup and/or the Review Panel when constituted will consider how the adult at risk and/or, appropriate representatives of the adult at risk, may be involved in the review process and kept informed about its progress. Please see section 6.4 for more information.

7.6 In constituting the review panel it is open to the SAR sub-group to include an "Expert by Experience" or a representative of a local or national service user or carer group. This arrangement is subject to the relevant checks being made (and the results being satisfactory) and the normal requirements on confidentiality being followed.

8. Conduct of a Safeguarding Adults Review

8.1 Throughout each SAR, the panel will keep in mind the experience and views of the adult at risk, and address how these were sought and taken into account by the professionals involved.

8.2 The SAR Panel will:

- establish what evidence will be required from each agency or person, stating whether this is through investigation or to be collected by way of Management Reviews (please see Appendix 3) or by other means;
- request further information from agencies as required;
- identify relevant policy, practice or procedural frameworks, both nationally and locally, that may be relevant to the conduct of the review;
- consider the facts and circumstances of the case and evidence received;
- cross-reference all agency management reports and reports commissioned from any other source;
- consider relevant professional and practice standards and guidance;
- analyse the evidence to understand why the incident took place. In particular, the panel will look for any wider systemic issues as well as individual practice issues;
- identify any areas of effective practice and areas for improvement;
- examine and identify relevant action points;
- agree the key points to be included in both reports and proposals for action; and
- agree the final version of the Review Report and Public Summary Report for submission.

8.3 If at any point, whilst undertaking the review, further information is received or issues emerge which require notification to a statutory body regarding significant omission by individual/s or organisations, this should be undertaken by the chair of the SAR Subgroup without delay.

8.4 A decision should be made as to whether the SAR process should be suspended pending the outcome of such notification. The reasons for the decision should be recorded and confirmed to all panel members, agencies, the chair of the board and statutory director.

9 Drafting the Review Report and Public Summary

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

- an account of events and any findings of fact together with a chronology developed from individual management reviews submitted;
- any matters of concern affecting the safety and wellbeing of adults at risk in Islington;
- any general public health, safety or well-being arising from the death of an adult at risk;
- any need to review policy, practice or procedures;
- dissemination to other local authorities;
- identification and integration of learning points from serious case reviews from other areas or research and best practice guidance; and
- information on references and sources used to prepare the report.

9.2 When the draft Review Report has been prepared and is considered to meet the requirements of the review, the SAR Panel will:

- send a draft of the report to contributing agencies and invite comments on factual accuracy;
- invite contributing agencies to confirm they are satisfied that their information is fully and fairly represented in both reports; and
- invite agencies to confirm that the draft recommendations, as they apply to their agency or more generally, are clear.

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

9.3 The SAR Panel will consider all comments and agree the final version of the Review Report and Public Summary to be submitted to the SAR Sub group. Once signed off by the SAR Panel, only the Chair of the SAR Panel, in consultation with the Review Panel, may make amendments to the content of the draft report, as part of arrangements for its validation and finalization.

10. Considering the recommendations of the Safeguarding Adults Review Panel

10.1 On receiving the SAR Panel's signed Review Report (including Public Summary), the SAR Subgroup will arrange to meet within two weeks to consider it. The subgroup will satisfy itself that:

- the terms of reference for the SAR have been met;
- the Review Report may be considered to be factually accurate and a balanced and fair representation of events;
- the Review Report contains a separate summary report (the Public Summary) that can be made public following board endorsement, including, as a minimum, information about the review process, key issues and recommendations;
- the content is sufficiently anonymised to protect the confidentiality of contributors, the adult and relevant family members/others, and avoid risk of inferential identification. In some cases the identity of the subject of the review will be in the public domain but care must still be taken to ensure sensitive personal information is protected, consistent with the conditions of confidentiality associated with the SAR process.

10.2 The SAR Subgroup may not amend the factual content, findings or conclusions of the Review Report. It is open to the subgroup, however, to invite the SAR Panel to give further consideration to certain points. It is then a matter for the SAR Panel to do so and to resubmit their report. It is the final decision of the SAR Panel to accept these points or not (please see section 9.3 for further details). Any conflict between the SAR Subgroup and SAR Panel that cannot be resolved between the two bodies will be referred to the chair and vice chair of the board for mediation and potential resolution.

10.3 The SAR Subgroup should satisfy itself that the conclusions reached are consistent with the factual information and that the recommendations flowing from the findings are sufficiently evidenced and proportionate. It is open to the SAR Subgroup to make additional recommendations. These should be noted separately from the SAR Panel's Review Report. If the SAR Subgroup decides not to accept a particular recommendation or to change a particular recommendation then again this will be identified separately. The subgroup's recommendations can be issued alongside the Review Report, prior to formal submission to the board. If the Chair of the SAR Panel, in consultation with the Review Panel, is content to accept the changes they can be incorporated into the original Review Report.

10.4 Once the full report and proposed public summary have been endorsed by the SAR Subgroup, the subgroup will:

- translate recommendations from the report into a prioritised action plan that is clear, realistic and contains defined time frames and accountable persons to ensure its delivery;
- offer an opportunity to the chair of the SAR Panel to comment on the proposed action plan;
- make sure that the Public Summary, recommendations and action plans are sent to individual agencies and subgroups of the board for implementation;
- make sure that the Care Quality Commission receive a copy of the final report and action plans;

- advise the chair of the board and statutory director accordingly; and
- submit the approved action plan to the next board for endorsement.

10.5 Arrangements will be agreed with the chair of the SAR Panel, chair of the SAR Subgroup and chair of the board, for the presentation of the Public Summary Report to the board for approval, publication and arrangements for monitoring and sign off. The board will ask the SAR Subgroup to make sure that all recommendations are carried out and seek updates on progress from individual agencies until the action plan is completed.

10.6 The action plan will show:

- who is responsible for various actions;
- timescales for completion of actions;
- the intended outcome of the various actions and recommendations;
- ways of monitoring and reviewing intended improvements in practice and/or systems; and
- who the report, or parts of the report, will be made available to.

10.7 The chair of board will make sure the statutory director is informed of progress and outcomes of all SARs.

10.8 The action plan will remain on the board agenda until the SAR Subgroup confirms all recommendations have been carried out.

10.9 The board will also report the outcome of every SAR completed in any one year's annual review.

11. Timetable

11.1 The process from the decision to conduct a review to the sign off of the final reports should normally be completed within six months. If a longer period is needed; this must be agreed with the chair of the board and statutory director.

11.2 In some cases it may not be possible to complete or publish a review until after Coroners or criminal proceedings have been concluded.

11.3 The family or representatives of the adult at risk will be kept informed of progress and of arrangements for publication of the Public Summary as appropriate.

12. Freedom of Information Act 2000 (FOI) & the Data Protection Act 2018 (DPA)

12.1 In the event of requests under the Freedom of Information Act 2000 or the Data Protection Act 2018 for copies of submissions to or the full report of any review or investigation, the FOI and DPA Lead in Islington Council must be informed immediately as all review materials are held in confidence by the SAR panel on behalf of the council's statutory director.

12.2 The FOI or DPA lead will take advice from the chair of the SAR Subgroup, who will consult the Panel Chair, on the individual case. If appropriate the Board Chair or the Statutory Director may also be consulted.

12.3 Consultation will take place over the possible application of exemptions under the Freedom of Information Act 2000.

12.4 Any decision to withhold requested information is subject to review and appeal. Therefore, it is important to ensure a record exists of how the public interest test was conducted and to seek advice from the council's legal team.

12.5 The council's FOI advisors will co-ordinate action for the review / appeal in accordance with the FOI Code of Practice.

12.6 Personal information may also be requested by data subjects under the Data Protection Act 2018. Subject access requests are also covered by specific regulations related to health and social work records. Please contact the Data Protection Lead Officer in the relevant organisation for further advice.

12.7 The Public Summary of every SAR will be published by the board in an anonymised form having regard to appropriate legal and other advice and any issues of inferential identification.

12.8 These provisions do not affect the normal arrangements for information-sharing between professionals for the purpose of a review.

12.9 For further general guidance on this legislation you may wish to refer to the relevant section on Islington Council's website.

Appendix 1

Safeguarding Adults Review Referral Form

Thank you for taking the time to refer your concern to us. We take all safeguarding concerns very seriously and are committed to learning from times when things go wrong.

Your referral will be considered by the Safeguarding Adults Review Sub-group of the Islington Safeguarding Adults Board. The sub group will follow criteria set out in our Safeguarding Adults Review policy which is called "A New Approach to Learning From Serious Safeguarding Cases" this policy can be found online at: http://www.islington.gov.uk/publicrecords/library/Adult-care-services/Information/Guidance/2015-2016/(2016-03-21)-Islington-Appendix-to-London-Safeguarding-Adults-Policy-Feb-2016.pdf
The panel can consider your case to take one of the following approaches:

A. Safeguarding Adults Review
B. Multi-agency Partnership Review
C. Multi-agency Reflective Workshop
D. Multi-agency Themed Audit

The Sub-group needs as much information as possible to enable members to make a proportionate decision as to how to respond to a request for a Safeguarding Adults Review. This ensures that if the request is accepted that maximum learning is achieved.

i. Tell us about you

Name:	
Position/Title:	
Agency (where applicable):	
Address:	
Telephone number:	
Email address:	
Senior Manager authorisation (if applicable) Name: Title: Contact details: Date referral authorised:	

ii. Who are you referring

Name:	
Date of birth:	
Gender:	

Date of death (where applicable):	
Address:	
Health (physical):	
Health (mental):	
What other agencies are/were involved with the individual?	

iii. Tell us about your concern

Please tell us about what went wrong	
How does this case meet the criteria for a Safeguarding Adults Review? (See Islington's Safeguarding Adults Review Policy 2015 mentioned at the top of the front page).	
What learning do you think can be achieved through review of this case?	
Have any other learning and review processes been followed? **(please attach any relevant reports)**	
Please detail any other relevant information that will enable the Safeguarding Adults Review Panel Sub-group of the ISAB to reach a decision about how to respond to this referral.	

Once the sub group has reviewed the referral we will respond to you to confirm its decision.

Please complete as much information on this form as possible and return to safeguardingadults@islington.gov.uk

Appendix 2: Determining the scope of the SAR

The SAR subgroup should consider, in the light of each case, the scope of the review and draw up clear terms of reference. Relevant questions include the following:

- What are the most important issues to address in trying to learn from this case?
- How can the information best be obtained and analysed?
- Who should be appointed as the author for the report?
- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?
- Might it help the SAR Panel to bring in an outside expert, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, for example how far back should enquiries cover and what is the cut-off point?
- What family history/background information will help to better understand what happened?
- Which organisations and professionals should contribute and what contribution should they be asked to make?
- Is there a need to involve organisations/professionals in other boroughs, and what should be the roles and responsibilities of the different boards with an interest?
- How should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the SAR process fit with the processes for other types of reviews?
- Who will make the link with interested parties outside the main statutory organisations, for example independent professionals, independent and voluntary organisations?
- When should the review process start, and by what date should it be completed?
- How should any public, family and media interest be managed before, during and after the review?
- Does the board need to obtain independent legal advice about any aspect of the proposed review?

Some of these issues may need to be revisited as the review progresses and new information emerges.

Appendix 3: Management Reviews by member agencies and independent organisations

1. When a case meets the criteria for conducting a SAR the Chair of the SAR Panel will formally request the agencies (and possibly some independent practitioners) to conduct a management review of their involvement with the adult, the service and/or their family and to submit a report, recommendations and where necessary an agency action plan arising from that review. The review and report should comply with the SAR's terms of reference, which will be sent with the request, and the guidelines contained in this appendix.

2. The management review, report and chronology (if appropriate) must be sent to the SAR Panel administrator by email within 6 weeks of the report being requested.

3. The request for a management review and report including a chronology if appropriate will be addressed to the chief officer or chief executive of the agency concerned (or directly to any independent practitioners identified in the recommendations of the SAR Panel). The task of completing the chronology, review, report and where necessary an agency action plan, should be delegated to a suitably qualified and experienced senior manager within the agency/service. This should not be the original caseworker or anyone who has directly managed the case. It is important that the management review, report, recommendations and agency action plan are fully endorsed by the chief officer before submission.

4. The aim of the management review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, identify how those changes will be brought about.

5. The SAR to which the management reviews contribute are not part of the disciplinary inquiry or process. However, information that emerges in the course of reviews may indicate that disciplinary action should be taken under established agency procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases, for example alleged institutional abuse; disciplinary action may be needed urgently to safeguard other adults at risk.

6. The format below should guide the preparation of the management review. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues which need to be explored, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of particular circumstances.

7. Where staff or those preparing the management review interview others, a written record of such interviews should be made and this should be shared with the relevant interviewee. If any individual is interviewed directly by the SAR Panel a formal note will be put on record.

8. A report of the management review should be completed, endorsed by the agency's chief officer and sent to the administrator of the SAR Panel within the time set out in the original request. Any foreseeable delays should be communicated to the Chair of the SAR Panel or the Chair of the SAR Subgroup.

9. The SAR Panel will collate and comment on the recommendations of each agency. Any additional action points identified by the panel will be discussed with the agency concerned and maybe included in the SAR Review Report. It is recommended that the management report should not be longer than 10 pages.

Content of Management Reviews

What was the agency's involvement with the adult at risk and/or their family?

A comprehensive chronology should be compiled of involvement by the agency and/or professional(s) in contact with the adult and family over a period of time set out in the review's terms of reference. Decisions reached should be briefly summarised, the services offered and/or provided to the adult, family/carer, and other action taken.

Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgments were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider:

- were practitioner's sensitive to the needs of the adult in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?
- did the agency have in place policies and procedures for safeguarding adults at risk and for acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult, family/carer? Do assessments and decisions appear to have been reached in an informed and professional way?
- did action accord with the assessments and decisions that were made? Were appropriate services offered/provided or relevant enquiries made in the light of the assessments?
- when, and in what way, were the adult's wishes and feelings ascertained and considered? Was this information recorded?

- was the person's mental capacity appropriately assessed and taken into account throughout the agency's involvement with the client?
- where relevant, were appropriate care plans or adult protection processes in place, and care plan reviews and/ or adult protection reviewing processes complied with?
- was practice sensitive to the racial, cultural, linguistic, age, disability and religious identity of the adult, and family/carer?
- were more senior managers or other agencies and professionals involved at points where they should have been?
- was the work in this case consistent with agency and Islington Safeguarding Adults Partnership policy, protocols and guidance for safeguarding adults at risk and wider professional standards?
- are there lessons from this case for the way in which this agency works to safeguard adults at risk and promote their welfare? Is there good practice to highlight ways in which practice can be improved? Are there implications for ways of working: training (single and inter-agency); management and supervision; working in partnership with other agencies; resources?

What has been learned from the case?

Each agency should produce and submit an action plan setting out any changes or improvements to their practice in light of this case. This should include possible disciplinary or regulatory action. The agency should set out how the plan will be reviewed to determine if the outcomes have been achieved.

Dissemination and Learning

The Individual Management Reviews are stand alone documents and should lead to individual actions by the respective agency:

- The agency-specific recommendations need to be implemented (**there is no need to await the outcome of the SAR)**
- The findings and recommendations from the management review need to be fed back to the relevant staff from the agency. This includes the media/communication, legal and environmental teams.

Appendix 4
Report by SAR Panel

The SAR report should bring together and draw overall conclusions from the information and analysis contained in the Management Reviews and any other reports.

The report should be produced according to the following outline format although, as with management reviews, the precise format depends on the features of the case.

SAR Panel Report Format:

a) Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to the review and the nature of their contributions.
- List panel members and the author of report.

b) The facts

- Set out a pictorial display of the person's relationship to family members, extended family and household and any care services provided.
- Compile an integrated chronology of involvement with the adult, family/carer on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the adult was seen and the adult's views and wishes sought or expressed.
- Prepare an overview that summarises what relevant information was known to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult.

c) Analysis

- This part of the report should look at how and why events occurred, decisions were made and actions taken or not taken.
- This is the part of the report where reviewers (those undertaking the reviews), can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.
- The analysis section is also where any examples of good practice should be highlighted.

d) Conclusions and recommendations

- This part of the report should summarise, in the opinion of the panel, what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action.
- Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation.
- Recommendations should be few in number, focused and specific, and capable of being implemented.
- If there are lessons for national as well as local policy and practice, these should also be highlighted.

Appendix 5

Islington Safeguarding Adults Partnership
Safeguarding Adults Review Panel: REF NO

I …….. ……[full name]

holding the position of ……..[job title]

within……[name of agency]

confirm my understanding and acceptance of the following confidentiality requirements in relation to this safeguarding adults review:

- All sensitive, personal and other information and documentation will be shared in confidence. This will be done consistent with the expectation that the duty of confidence will be maintained in line with the requirements of Data Protection legislation and local protocols for the sharing of information; including Caldicott requirements within health, education and social care.

- All information received or given (including all documentation and notes, whether in electronic or manual form) must be held securely and safely. All material relating to the review must be kept together in one place. This includes information stored electronically which will normally be supplied in protected form.

- Electronic data may only be stored on agency systems. Memory sticks or other portable devices must not be used for this purpose.

- All documentation should be marked 'Confidential' and may not be disclosed to others without the prior written consent of the Chair of the SAR Panel or the Chair of the SAR Subgroup.

- All information discussed at panel meetings or within the partnership as part of this review is and remains strictly confidential. It may not be discussed, disclosed or in any other way made available to other parties without the prior written consent of the Chair of the SAR Panel or the Chair of SAR Sub group.

- The unauthorised disclosure of information outside of meetings, beyond that which has been agreed and recorded within the minutes of the panel or board meeting, may have legal consequences. It would be considered as a breach of the data subject's confidentiality and a breach of the confidentiality requirements of the agencies involved.

- All information and documentation supplied as part of the review becomes and remains the property of the Islington Safeguarding Adults Board. It remains the confidential property of the board even when stored within agency systems. All materials must be returned to the Chair of the board or the Chair of the SAR

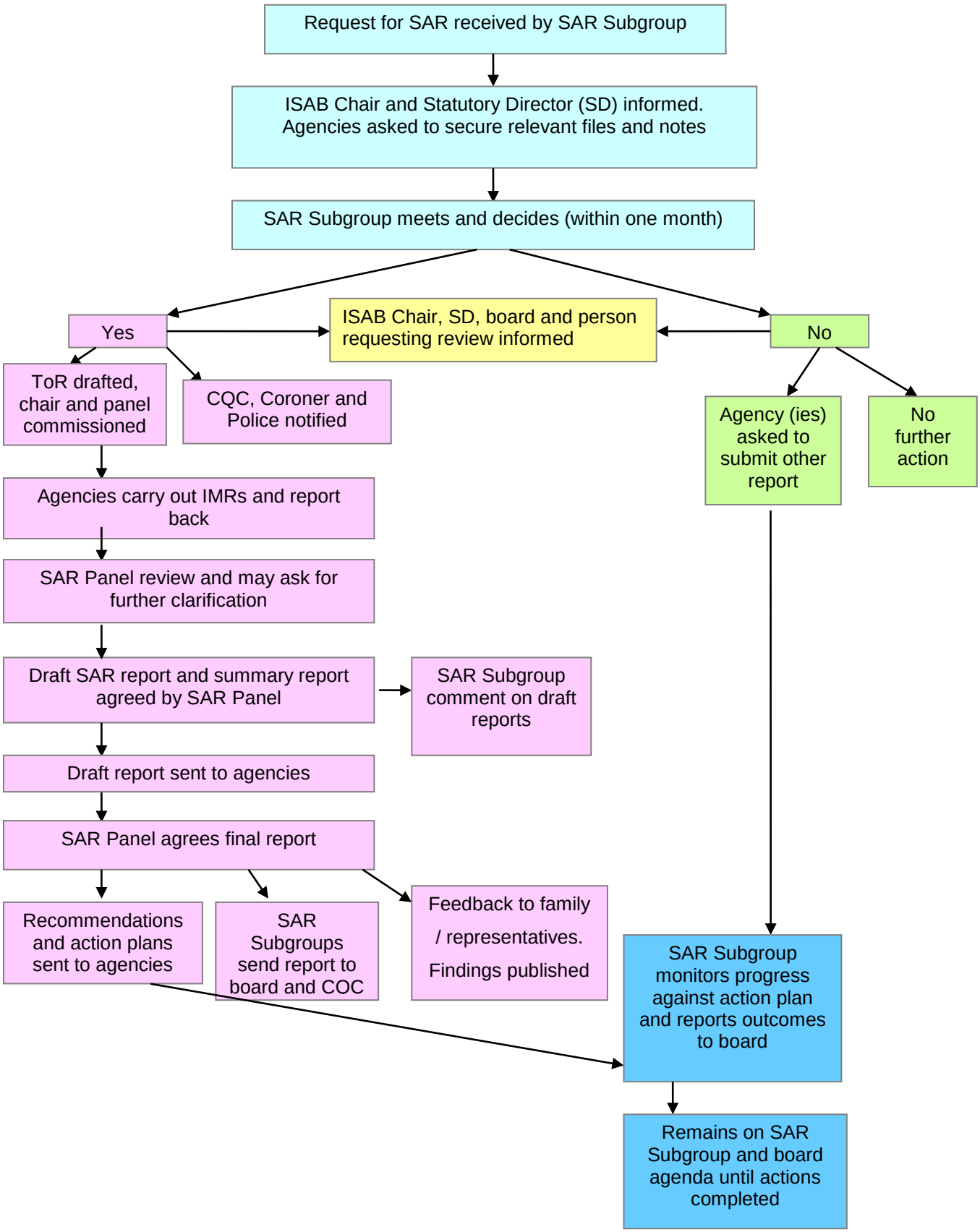
Subgroup on being requested or at the end of meetings, or at the end of the review process.

- Confirmation of secure destruction will be provided.
- Advice on these requirements is available from the Chair of the SAR Subgroup and or Chair of the board.

Signed: ……Dated: ……

Appendix 6

Islington Safeguarding Adults Review Flow Chart



Sources

The following sources were used in the development of this document:

Care Act 2014 and Care and Support Statutory Guidance.

ADASS (2005) Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work

ADASS (2006) **Vulnerable Adult Serious Case Review Guidance**

Birmingham City Council (2009) **Serious Case Review Policy**

Manthorpe, J. and Martineau, S. (2009) **Serious Case Reviews in Adult Safeguarding**

Manthorpe, J. and Martineau, S. (2010) **'In our experience': Chairing and commissioning Serious Case Reviews in adult safeguarding in England**

Manthorpe, J. and Martineau, S. (2011) **Serious Case Reviews in Adult Safeguarding in England: An Analysis of a Sample of Reports**

Ofsted (2008) **Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008**

SCIE (2009) **At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews**

SCIE (2010) **At a glance 34: Piloting the SCIE 'systems' model for case reviews: Learning from the North West of England**

SCIE (2015) **Safeguarding Adults Reviews under the Care Act – implementation support**

Solihull Safeguarding Adults Board (2009) **Serious Case Review Procedure**

Surrey Adult Protection Committee (2005) **Serious Case Review**

Warwickshire Safeguarding Adults Board (2009) **Warwickshire Inter-Agency Safeguarding Adults Serious Case Review Policy and Procedure**

Appendix J: Information Sharing

Sharing the right information, at the right time with the right people, is fundamental to good safeguarding practice, but it has been highlighted as a difficult area of practice. The Care Act 2014 Section 45 'supply of information' duty covers the responsibilities of others to comply with requests for information from the SAB. Sharing information between organisations as part of day-to-day safeguarding practice is covered by the common law duty of confidentiality, the General Data Protection Regulation (GDPR), Data Protection Act 2018, the Human Rights Act 1998 and the Crime and Disorder Act 1998.

As a general principle people must assume it is their responsibility to raise a safeguarding concern if they believe an adult at risk is suffering or likely to suffer abuse or neglect, and/or are a risk to themselves or another, rather than assume someone else will do so. They should share the information with the local authority and/or the police if they believe or suspect that a crime has been committed or that the individual is immediately at risk

Partner organisations may be asked to share information through agreed information sharing protocols. SCIE has produced helpful practice guidance. Islington Safeguarding Adults board has an Information Sharing Agreement agreed amongst all board partners which can be found on the Islington website.

Confidentiality

A duty of confidence arises when sensitive personal information is obtained and/or recorded in circumstances where it is reasonable for the subject of the information to expect that the information will be held in confidence.
Adults at risk provide sensitive information and have a right to expect that the information about themselves that they directly provide, and information obtained from others will be treated respectfully and that their privacy will be maintained.
The challenges of working within the boundaries of confidentiality should not impede taking appropriate action. Whenever possible, informed consent to the sharing of information should be obtained. However:

- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.
- The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified.
- The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

Whether information is shared with or without the adult at risk's consent, the information sharing process must abide by the principles of the General Data Protection Regulation. The GDPR should not be a barrier to sharing information. It provides a framework to ensure that personal information about living persons is shared appropriately.

In those instances, where the person lacks the mental capacity to give informed consent, staff should always bear in mind the requirements of the Mental Capacity Act 2005, and whether sharing it will be in the person's best interest.

For more information contact, please email FOIA@islington.gov.uk

Appendix K: Data protection Act 2018 Six Principles

Principle 1	The first data protection principle states that data must be processed lawfully and fairly
Principle 2	Personal data shall be collected for specified, explicit and legitimate purposes for which they are processed.
Principle 3	Personal data shall be adequate, relevant and limited to the necessities of the purposes for which they are processed.
Principle 4	Personal data shall be accurate and, where necessary, kept up to date.
Principle 5	Personal data must not be kept for longer than is necessary for the purpose for which it is processed.
Principle 6	Personal data shall be processed in a manner that ensures the appropriate security of the personal data.