Dorset Safeguarding Adults Board
and
Bournemouth, Christchurch & Poole Safeguarding Adults Board

Safeguarding Adults Review Policy

Version Control

Version number	Purpose of the change or details of the change	Person making the change	Date
1.0	Initial Policy Agreed May 2015.		
2.0	Revised Policy Siân Walker-McAllister September 2021.		
3.0	Revised by Siân Walker-McAllister and Kirsten Bland. May 2024.		

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Contents

1. Introduction

Section 44 of the Care Act 2014 (the act) and associated statutory guidance requires all Safeguarding Adults Boards (SABs) to conduct Safeguarding Adults Reviews (SARs) (previously known as serious case reviews) in certain circumstances and permits SABs to arrange SARs in other circumstances. The Act requires Board member agencies to cooperate with and contribute to the carrying out of a SAR.

"The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm."

Care and Support Statutory Guidance (DH: 2010) paragraph 14.135.
Care and support statutory guidance - GOV.UK (www.gov.uk)

SABs 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 concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. 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 has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.

No single review model will be applicable for all cases: review methodology should be determined by the circumstances of each case. This is referred to at Section 6 of this report.

SARs may be complex and detailed or may take account of other reviews undertaken (whether statutory or not). They are undertaken for the purpose of understanding and learning from individual cases to continuously improve the effectiveness of the wider system working together.

2. Purpose of Safeguarding Adults Review (Learning not blaming)

The purpose of holding a SAR is not to investigate or to apportion blame; its purpose is to produce learning from a particular case with the aim of preventing future deaths/serious abuse, harm or neglect occurring.

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented serious abuse, harm, neglect, or death. A SARs is not to hold any individual or organisation to account – other processes exist for that purpose which include each partner organisation's own disciplinary or separate learning processes.

All organisations which are party to a SAR should ensure that there is robust governance within their own organisations. Equally important is that each organisation supports the communications and publication strategy following completion of a SAR or whilst it is in process.

Criteria for Safeguarding Adults Review – this outlines that which is stated in the Care Act 2014 statutory guidance.

2.1. A SAB is the only body that can commission a SAR. As set out in S44 of the Care Act 2014, a SAR must take place when:

- an adult 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.
- adult has experienced serious abuse or neglect but has not died.

2.2. "Serious abuse or neglect" may include:
- the individual would have been likely to have died but for an intervention,
- the individual suffered permanent harm as a result of abuse or neglect,
- the individual has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.
- the individual has sustained a potentially life-threatening injury through abuse or neglect,
- the individual has suffered serious sexual abuse.
- This is not an exhaustive list. The final decision rests with the DBCPSAB or delegated SAR panel as to whether abuse/ neglect was serious enough to warrant a SAR.

2.3. In addition, SABs are also free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

2.4. There is no requirement for a case to have gone through a Section 42 safeguarding adults' enquiry before it can be considered for a SAR.

2.5. A discretionary SAR should only be commissioned when there is potential to identify sufficient and valuable learning to improve how organisations work together, to promote the wellbeing of adults and their families, and to prevent abuse and neglect in the future.

2.6. Appropriate cases for a discretionary SAR may include:

- Serious incidents that do not meet the criteria for a SAR but that the SAB wants to review.
- A case featuring repetitive or new concerns or issues which the SAB wants proactively to review in order to pre-emptively tackle practice areas or issues before serious abuse or neglect arises.
- A case featuring good practice in how agencies worked together to safeguard an adult with care and support needs, from which learning can be identified and applied to improve practice and outcomes for adults.
- The criteria for carrying out a SAR is broad and therefore the approach taken should be proportionate according to the scale and level of complexity of issues being examined. A SAR can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults or explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Learning that the Safeguarding Adults Review needs to accomplish.

In any SAR there is a need to achieve an understanding of:
- What happened?
- Any errors, absence of good practice or problematic practice and/or what could have been done differently.
- Why those errors, absence of good practice or problematic practice occurred and/or why things did not happen differently, for example any systemic issues preventing good practice?
- Which of those explanations are unique to this case and context, and what can be extrapolated for future cases to become recommendations for learning?
- Whether any of the issues identified were also present in previous reviews and, if so, whether steps have already been taken to improve practice as a result?

- What remedial action needs to be taken in relation to the findings to help prevent similar harm in future cases?
- Whether good practice is identified.

3. Governance process for SARs

All referrals for SARs will be considered by the SAB SAR Subgroup and decisions will be made whether a referral meets the criteria for commissioning a SAR. A recommendation will then be made to the SAB's Independent Chair & Board.

Terms of Reference of the SAR subgroup are attached at **Appendix 1.**

4. Making a decision on the methodology to be used when commissioning a SAR.

A range of methodologies or tools can be used to undertake the necessary investigations to deliver a SAR.

No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding and learning. There must always be a consideration of how family and friends can achieve clarity and understand what happened; and consideration given to their involvement and contribution (as appropriate) to the Review.

The Safeguarding Adults Board Subgroup will agree the methodology to be used for the SAR. Different methodologies are shown at **Appendix 2.**

5. Principles to be applied to all SARs.

The following should be applied to all reviews:

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined and will be overseen by the Board through its delivery of a Review and Action Plan.
- When the SAR criteria is met, consideration should be given to other statutory reviews which are taking place simultaneously or may have precedence (See also Point 9 below).
- SARs should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed (not necessarily an independent overview author). This includes SAR Panel Chairs and SAR Lead Reviewers/ Authors.
- All relevant professional organisations (who were engaged with the individual) should be involved fully in SARs and invited to contribute to 'Individual Management Reviews' (IMRs) and learning and practitioner events.
- Where an individual, about whom a SAR is commissioned is alive, there should be consideration given as to whether, at the point of referral, consent has been sought from the individual. If they decline or do not consent to a referral or commission of a SAR then consideration under *Article 9 of the General Data Protection Regulations (GDPR), which states that the processing of special category or sensitive personal data must have a lawful basis. For the purposes of Reviews, that lawful basis is Article 6 GDPR, which states processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the Controller.* See the following link: https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/lawful-basis/a-guide-to-lawful-basis/lawful-basis-for-processing/vital-interests/

- The individual should be involved in the process of the SAR to contribute about their own experience. If they have any significant difficulty in being involved, an advocate may help them to be as involved as far as possible in the process.
- Families and/ or friends should be invited to contribute to reviews, where appropriate. They should be informed when a SAR has been commissioned and the SAR Subgroup Chair or Lead Reviewer (or another appropriate person) such as an involved professional should clearly communicate with them so that they understand how they are going to be involved. Their expectations should be managed appropriately and sensitively.

The options for conducting a SAR are detailed in the appendices, as are the skills required of a SAR Author.

6. Timescales

In general, SARs should be completed within 6 months from the lead reviewer/ author being appointed, unless otherwise specified or alternative date agreed by the SAR Panel.

7. Joint Reviews

The SAR subgroup will seek to identify at the outset whether other reviews and processes are taking place or envisaged in relation to the same case. Where there are possible grounds for any other Statutory Review e.g., Domestic Homicide Review (DHR), Child Safeguarding Practice Review (CSPR), or a Mental Health Homicide Review (MHHR), then a decision should be made at the outset by the Independent SAB Chair & Board involved as to:

- Which process is to lead.
- who from the SAB or partner organisation might be involved in the other statutory review.

Whether some aspects of the reviews can be commissioned jointly should also be considered, to reduce duplication and enhance learning. It will be important that terms of reference for related reviews effectively cover all aspects of the case.

Where NHS organisations carry out 'Patient Safety Reviews' (PSIRF process), all local NHS providers and/ or the local Integrated Care Board (NHS Dorset) will determine whether there also needs to be a referral for a SAR.

The SAB (via the Business Manager) will inform the Coroner after each SAR subgroup, of any new SARs to be commissioned. This will enable the Coroner to determine whether to proceed with an Inquest or whether to wait until the SAR has concluded. This will also enable timely decisions to be made about commissioning SARs.

A coroner is legally entitled to request information provided to SARs as well as the overview report itself. When a Coroner requires information, correspondence will be with the Chair of the Safeguarding Adults Board. Guidance in relation to the separate coronial inquest and SAR processes will set out a framework and how this will be achieved. It will be appended when approved.

8. Process for Initiating a Safeguarding Adults Review, Complaints and Appeals

Anyone e.g., a member of the public, agency or professional, may refer cases to the SAB for consideration for a SAR. Referrals must be made using the form (attached at **Appendix 3**). The SAB Business Manager will scrutinise the referral and seek more information before finalising a referral to the SAR subgroup - *Consideration of GDPR will be applied*. This may include going out to partner agencies for initial information gathering. The SAR Subgroup will decide if the case meets the SAR

criteria and refer the final decision to the Independent SAB Chair. The decision to commission a SAR lies with the Board. In order to promote an efficient process, the Board will delegate such decisions to the Independent SAB Chair and will receive a quarterly report on decisions made, retrospectively.

In the event of a decision being made that the SAR criteria is not met, the reasons need to be recorded by the SAB Business Manager and shared with the referrer. This will also be noted in the meeting minutes and on the referral form.

If a decision is made to commission a SAR, the SAB Business Manager will send out Information Management Review (IMR) requests to appropriate organisations.

10.1 Appeals against decision not to commission a SAR

If the referrer wants to appeal against a decision not to commission a SAR, the appeal should be put in writing to the Independent SAB Chair, who will review the decision within 6 weeks, seeking further clarification from the subsequent SAR Subgroup. The Independent SAB Chair may take legal and other professional advice and s/he will write to the referrer setting out why the referral did not meet SAR criteria or, whether the matter has been reconsidered and explaining what other actions may be taken.

9. Information Management Reviews (IMRs)

IMRs are documents required of all parties/organisations contributing to a SAR and who were involved with the individual. These will be requested by the SAB Business Team and all organisations are expected to complete the template setting out the chronology of their involvement with the individual and their analysis of their interventions and the outcomes.

This ensures that all SARs are able to include clear and concise findings.

10. Annual Report and SAR Outcome Reporting

The SAB must include information about the findings from any SAR in its Annual Report and what actions it has taken or intends to take in relation to those findings.

Where the SAB decides not to implement an action then it **must** state the reason for that decision in the Annual Report.

If a decision has been made by the SAB not to publish a SAR, it will be referred to using an acronym in the Annual report with minimal appropriate information given.

11. Additional Considerations for a SAR which will be determined by the SAR Panel

Consideration will always be given to the proportionate methodology to be used for delivery of each SAR. Examples of different SAR methodologies are attached at **Appendix 2**. Where a Joint Review takes place, there should be an agreement on the parameters of the Review, including any financial arrangements, between the relevant Board Chairs at the outset. Where the DBCPSAB has been invited to contribute to a SAR commissioned by another SAB, the decision will be taken by the Independent SAB Chair

Agencies should adhere to the Pan-Dorset Overarching Information Sharing Agreement and Board's Personal Data Exchange Agreement. This is known as PISA.

As required under s45 of the Care Act, each agency must ensure that information, including accurate and secure records required for delivery of the SAR are available for the SAR author, at the time

required and as requested by the SAR Panel. Failure to adhere to this will result in immediate escalation to the Independent SAB Chair who will take action with the relevant organisation.

Each SAR must take account of relevant legislation, e.g., Care Act 2014, Mental Health Act 1983, Mental Capacity Act 2005 and other such legislation as may be appropriate.

A communication strategy will be agreed for each SAR between the SAR Subgroup Chair and the SAB Chair.

12. Terms of Reference for SAR Subgroup

The terms of reference for the Safeguarding Adult Review subgroup are listed **in Appendix 1.**

13. The Process – See **Appendix 3 SAR Process**

14. SAR Quality Markers

The Social Care Institute for Excellence (SCIE) and others published the SAR Quality Markers in 2023. These quality markers are to be used by all SAR Lead Reviewers/ Authors and are attached **via the following link**. List of 15 Safeguarding Adult Reviews Quality Markers - SCIE

The expectation that SARs will deliver against the quality markers will be explicit when commissioning a SAR and the SAR Panel will use the Quality Markers in reviewing progress of SAR delivery at Panel.

15. Commissioning a Lead Reviewer/Author

The SAR Subgroup will agree the skillset required for a potential appropriate SAR Lead Reviewer/ Author.

The process for procuring a SAR Author is the responsibility of the SAB Business Team and a preferred author will be selected from a list by the SAR subgroup Chair, SAR Panel Chair and Independent SAB Chair.

When selected, a SAR Author/ Lead Reviewer will be given copies of the SAR Referral, the proposed Terms of Reference for the SAR and dates will be agreed for all panel meetings and practitioner events. This will include the proposed SAB meeting when the final draft of the SAR will be presented.

Procurement will be in accordance with the financial rules of the lead authority.

SARs must be written in plain English, accurate, show logical sequencing and show SMART (Specific, Measurable, Achievable, Realistic and Timed) recommendations and delivered in accordance with the SAR Quality Markers.

There will be a maximum of 3 SAR Panels and at minimum there will be 2 Panels (depending on the methodology used):

- Panel 1 to finalise Terms of Reference and enable opportunity for the author/ lead reviewer to ask questions following receipt and initial analysis of IMRs. It will also be necessary to agree timescales for all events in the process at this meeting.
- Panel 2 will receive the first or final Draft report.
- Panel 3 will receive a final draft report if not resolved at Panel 2.

The SAR Panel Chair is responsible for seeking agreement from all contributing agencies that they are satisfied that the report reflects the information shared and discussions held as part of the review. It is therefore important that each agency and partner to the SAB delegates responsibility to their Panel member to take decisions on behalf of that agency. If a Panel Member has a query about a decision to be made, it is essential that they raise this immediately with the Panel Chair so that timely actions may be undertaken. If it is not possible to obtain agreement, the person leading the review and the SAR Subgroup Chair take the final decision on the report content, in conjunction with senior representatives of that agency. The Chair of the SAB should be notified where agreement has not been obtained from all agencies at the earliest opportunity.

16. Action Plans and Recommendations following a SAR

The SAB Business Manager is responsible for drafting the SAR Action Plan to be presented to the SAR subgroup with the final SAR report. Action plans derived from SMART recommendations must have robust outcomes that can be monitored and measured.

The SAR Subgroup will need to agree the Draft SAR Action Plan which will be submitted to the SAB for decision alongside the final Draft SAR report.

Completion of actions in the plan will be monitored by the SAR subgroup and reported regularly to the SAB. A review will only be closed when the SAB is satisfied that all the actions have been completed. The relevant Board subgroups will determine if there should be any longer term follow-up of the impact on practice of the recommendations of the review as part of its annual audit plan.

17. Learning and Dissemination following a SAR

Learning and dissemination of learning from Safeguarding Adult Reviews will be led by individual agencies with oversight by the appropriate SAB subgroup. A range of methods for disseminating and briefing staff will be used, including formal learning events, on-line learning and 7-minute briefings. Any new learning must be integrated into each organisation's own regular adult safeguarding training programmes. The SAB Business Manager will draft the initial 7-Minute Learning Review and ensure that this is agreed by the SAR Subgroup.

Each partner agency will be asked to assure the SAB that they have allocated sufficient time and resource for staff to integrate the lessons into practice and this will be reviewed at the Annual SAR Event hosted by the SAB.

18. Publication

SARs will be published and placed on the SAB website. A decision not to publish is by exception where there is a need to protect anonymity of the individual or their family members. This will have been agreed by the SAB at the time the draft SAR was presented and agreed.

In all circumstances and in particular where there may be public interest in the findings of a review, the SAB will take a more proactive stance and in line with the SABs Communications Strategy; take the appropriate steps. In these circumstances the SAB will work alongside and expect that partner organisations' Communication Leads are proactive and working together with one Lead Agency, producing a joint press release and FAQs. The Independent Chair of the SAB will act as the spokesperson on behalf of the Board.

Once a SAR is published it must be sent to the National Network of SAB Chairs for inclusion in the National SAR Library.

Appendix 1 Terms of Reference for the Safeguarding Adult Review Subgroup

SAFEGUARDING ADULTS REVIEW SUBGROUP

TERMS OF REFERENCE

The Safeguarding Adults Review subgroup (SAR subgroup) is a sub-committee of the Dorset and Bournemouth, Christchurch & Poole Safeguarding Adults Boards (DBCPSAB) and has powers specifically delegated in these terms of reference.

1. Purpose

To oversee Safeguarding Adults Review (SAR) functions on behalf of the DBCPSAB consistent with the Boards' Safeguarding Adults Review Policy and to ensure they are consistent with national guidance and any relevant local policies. To make recommendations to the Independent SAB Chair and to the Board on commissioning of Safeguarding Adult Reviews.

To ensure delivery of SARs in a timely way, through arranging SAR Panels to provide governance for SAR's in accordance with Section 44 of the Care Act 2014.

To oversee delivery of final drafts of SAR reports for approval by the Safeguarding Adults Boards.

2. Objectives

- To receive and consider referrals of SARs from any partner or member of the public, making recommendations to the Independent SAB Chair and the Board when the SAR criteria are met for the commission of a SAR.
- To agree and to establish the draft Terms of Reference for each of the SARs commissioned and to determine the methodology to be adopted for delivery of the SAR.
- To determine the skill set required of potential Independent Authors/ Learning Review facilitators and to determine whether the SAR Panel Chair can be a local partner; or whether an independent Panel Chair needs to be commissioned.
- To provide effective governance of the SAR process and to receive reports from the SAB Business Manager in respect of progress of information received, shared and analysed by the Independent Author/Reviewer.
- To ensure that all agencies which are requested to supply information under S.45 of the Care Act, do so, in good time so that SARs can be delivered on time. In the event of a failure, to escalate the matter to the Independent SAB Chair.
- To establish appropriate contact with family members from the start and to ensure that they are informed and involved in the conduct of the SAR.

3. Specific Remit/Duties

a) Secure compliance with the DBCPSAB Safeguarding Adult Review Policy.

b) To consider the SAR request and make recommendations to the Independent SAB Chair on the appropriate methodology for each Safeguarding Adult Review; and the experience required of an Independent Author/Reviewer.

If a referral for a SAR has or is already being reviewed via another statutory process, for example a Domestic Homicide Review (DHR), or a Mental Health Homicide Review (MHHR), the Business Manager must ensure that the subgroup is informed and able to influence other processes when the matter is also deemed to meet the SAR criteria. In such cases, the SAR Subgroup must request involvement in the setting of terms of reference for those reviews so that safeguarding perspectives may be considered.

If the criteria for a SAR is not met then the subgroup may take other approaches as follows:

- If it is felt that there could still be important learning to be derived from a more proportionate review of a case, then the SAR subgroup should request appropriate involvement and ensure feedback to appropriate partners at the end of the process.

- If the case involves actions by a single agency, then the SAR subgroup, on receipt of the final report may seek assurance and request feedback from the organisation as to improvement actions taken.

c) Ensure that recommendations from each SAR are specific, measurable, action oriented, realistic and timed (SMART) so that these can easily inform the SAR Action Plan which is to be drafted for approval by the SAB alongside the SAR in its entirety.

d) Ensure confidentiality is maintained and adhered to in relation to information shared for Safeguarding Adults Reviews within the parameters of the Personal Information Sharing Agreement (PISA).

e) Clarify, advise and refer decisions on the sharing or dissemination or publication of reports (in whole or in part) to the Safeguarding Adults Board.

f) Ensure that communication with family members is carried out. In conjunction with the SAB's Independent Chair, ensure that a Communication Plan is agreed with appropriate briefings for staff, family members and media as appropriate. In the case of the media – the SAR subgroup must decide whether the SAR is published proactively or whether reactive press statements are prepared in advance before SAR publication.

g) Promote transparency and objectivity and ensure declarations of interest and any conflicts of interest are identified at all meetings and during reviews.

h) Ensure involvement by or with other relevant bodies e.g. CQC, DHSC, Home Office, Coroner, National SAB Chairs' Network and any other relevant professional, government or regulatory agency as required. The SAB Business Manager will regularly advise the Coroner, through the Independent SAB Chair of reviews which are to be commissioned and the likely timescales for completion, in accordance with the Coroner's 'Worcestershire Case' Agreement.

i) Report quarterly to the DBCPSAB on the progress of SARs currently under commission

j) Maintain a forward plan of work and set time aside each year to:

- Review achievements and improvements.
- Assess effectiveness.
- Consider future requirements.

4. Membership of the SAR Subgroup

The Chair and Deputy Chair is agreed by the Safeguarding Adults Boards

Membership will include:

- Bournemouth, Christchurch & Poole Council adult social care
- Dorset Council adult social care
- NHS Dorset
- Dorset Police
- Representative of the 2 Community Safety Partnerships as appropriate to the agenda
- Business Managers of each Safeguarding Adults Board

Representatives of other organisations e.g. any NHS Provider organisation which is involved, and other organisation may be invited to the subgroup to participate in discussion, support decisions and provide information about specific cases, for as long as discussions about SARs relating to that organisation remain on the agenda and on the 'Active SAR Tracker'.

4. Quorum/Voting

For the subgroup to be quorate, membership must include representation from each of the statutory partners, plus the Chair or Deputy Chair.

6. Organisation, Frequency of Meetings, Administration

Meetings to be arranged every six weeks, however these may be cancelled if there is insufficient business. Administrative support will be arranged by the Business Managers.

7. Standing Agenda Items

- Welcome and Apologies.
- Minutes and Matters Arising.
- Safeguarding Adult Review Tracker & Summary – progress and updates.
- Referrals for Safeguarding Adults Reviews.
- Progress on Reviews under commission.
- Progress on Action Plans.
- Any other Business.

8. Governance

This SAR subgroup reports to and is a subgroup of the DBCPSAB.

For each SAR, the subgroup sets up a time-limited Task and Finish group (known as the SAR Panel) to oversee work on a SAR using the methodology agreed with the lead reviewer.

Where a referral does not meet the criteria for a SAR the subgroup may request that a task and finish group is established and reports back on any learning from the case.

9. Monitoring Effectiveness, Review Date

To be reviewed annually and as requested.

10. Document Owner

Updates:

Date	Contact	Version	Page	Details of Change
June 2021	SAB Business team	1.0	Appendix 1	
June 2024	SAB Business Team & SAB Chair & SAR Subgroup Chair	2.0	Whole Document	Biannual Update

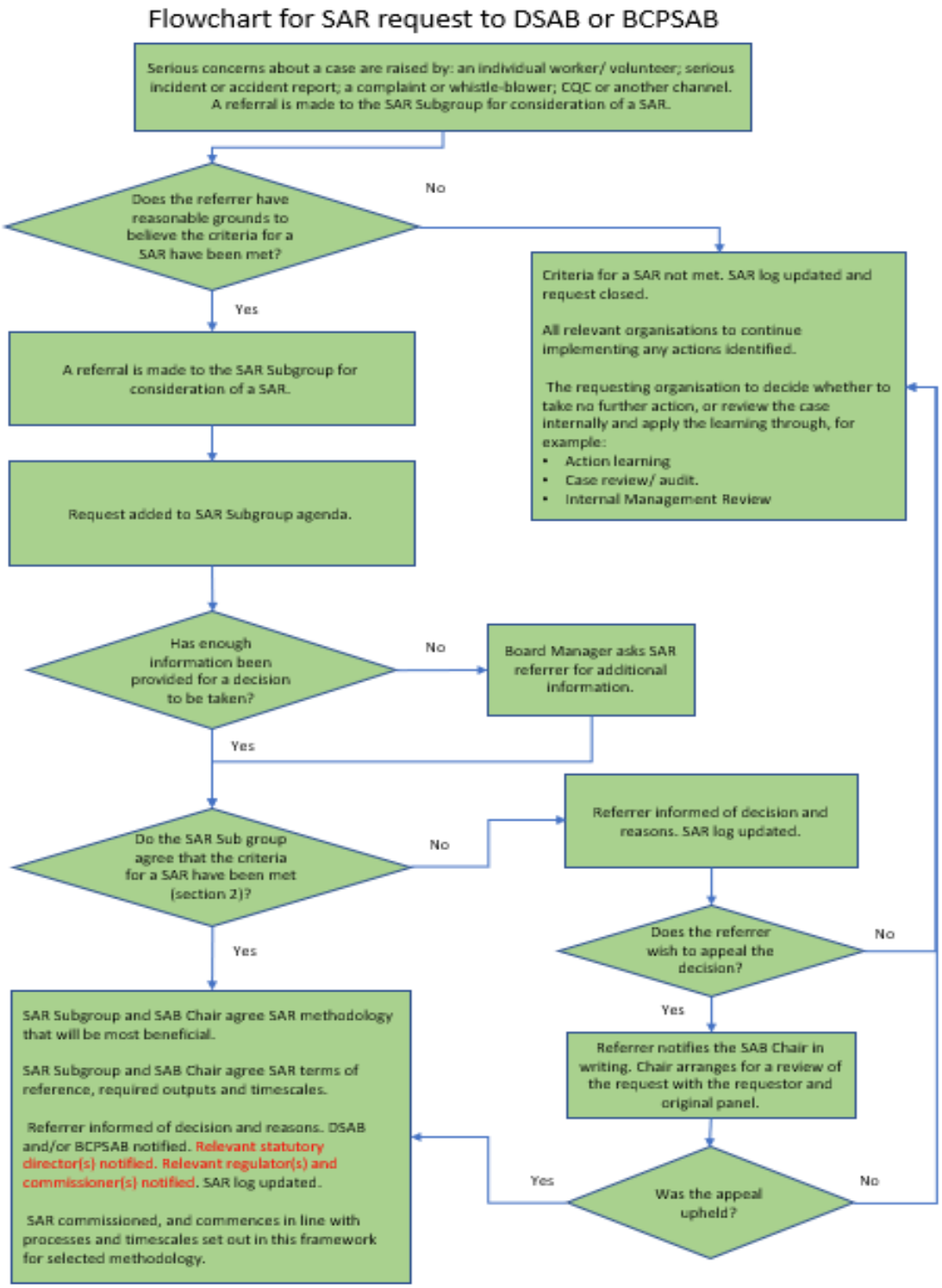
Appendix 2 Safeguarding Adult Review Methodologies

Types of Methodologies	Process to follow
1 Significant Event Analysis or Audit This SAR methodology brings together managers and/or practitioners to consider significant events within a case and together analyse what went well and what could have been done differently, producing a joint plan with recommendations for learning and development	The process followed in a Significant Event Analysis or Audit is as follows: • Information Gathering-collation of as much factual information about the event as possible from a range of sources • Facilitated workshop to analyse the event(s). The workshop needs to be operated fairly, openly and in a non-threatening environment. • Analysis of the Significant Event. The key questions that require answering in a Significant Event Analysis or Audit are: o How could things have been done differently? o What can be learnt from what happened? o What has been learnt? o What has been changed or actioned?
2 Systems Review The 'Systems' model established is a means of identifying which factors in the work environment support good practice; and which create unsafe conditions in which poor safeguarding practice is more likely. It is a collaborative model for SARs - those directly involved in the case are centrally involved in the analysis and development of recommendations	A systems approach to conducting a Safeguarding Adults Review involves: • Scoping of review/Terms of Reference: identification of key agencies/personnel, roles, timeframe (completions, span of person's history) specific areas of focus/exploration. • Appointment of facilitator and overview report author. • Production/review of relevant evidence, the presiding procedural guidance via chronology, summary of events and key issues from designated agencies. • Material circulated to attendees of learning event, anticipated attendees to include members from the DBCPSAB, front line staff, line managers, agency report authors, other co-opted experts (where identified) facilitator and/or overview report author. • Learning event(s) to consider what happened and why, areas of good practice, areas for improvement and lessons to be learnt. • Consolidation into an overview report with analysis of key issues, lessons learned and recommendations. • Event to consider first draft of the overview report and action plan. • Final overview report is presented to DBCPSAB, agree dissemination of learning and monitoring of implementation. • Follow up event to consider action plan recommendations • On-going monitoring via the DBCP SAR subgroup

3 Using Individual Management Reviews to Analyse Individual Agency Performance Individual Management Reviews (IMRs) are intended as a means of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. IMRs identify good practice, where systems, processes and (individual and group) practice could be enhanced.	IMR's are a tool that can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-top based review , or a review involving a multi-agency review panel whether as part of a one-off workshop or a review following a the traditional Safeguarding Adults Review model. Most popular methodology used. A hybrid version of using IMR's and the Significant Event Analysis is often used
4 Multi-agency combined Chronology Developing a chronology of events is a useful way of achieving an overview of a case or situation and considering the areas for development or change. With a combined chronology, the perspective is greatly enhanced and enables us to identify not only gaps in service(s) or practice, and therefore areas for development, but also missed opportunities for communications between agencies. A SAR can also use a combined chronology with a focused timescale of consideration to enable lead practitioners and managers to reflect on a case within a facilitated workshop setting and develop timely recommendations for change.	Chronologies are important tools that are particularly useful when combined across agencies. It enables a group of agencies to identify gaps in communication, shared decision making and risk assessment. A combined chronology can be used to help agencies analyse and reflect on their work with an individual or group of individuals and make recommendations for change. These can be used as part of a desk-top review or a review involving a multi-agency review panel., whether as part of a one-off workshop or a review following the traditional Safeguarding Adults Review model.
5 Traditional Safeguarding Adult Review Model, using a Combined Chronology Individual Management Review and a Review Panel For a complex case, this method involves all agencies in completing IMR's, a chronology and a review panel.	This method will provide a detailed analysis of agencies work with an adult or group of adults and provide a familiar approach to learning. The SAR subgroup should give careful consideration to any additional value achieved through this approach. Safeguarding Adults Reviews are resource intensive and can be highly sensitive for the individuals and organisations involved. It is vital they are managed with a clear governance framework
6 SAR in Rapid Time Model The Safeguarding Adult Reviews in Rapid Time (SARiRT) model provides a process and related tools that support reviews to draw out systems learning to promote practical improvement using a timely and proportionate approach.	The model encourages clarity about the kind of learning needed, so that the review can move from purely describing practice problems to illuminating what lies 'behind' those practice problems. Taking a systems approach, the model enables us to understand the social and organisational drivers for current practice problems. The process supports reviews to be turned around more quickly (we aim for three months to produce the final report) and to provide a shorter more focussed final report.

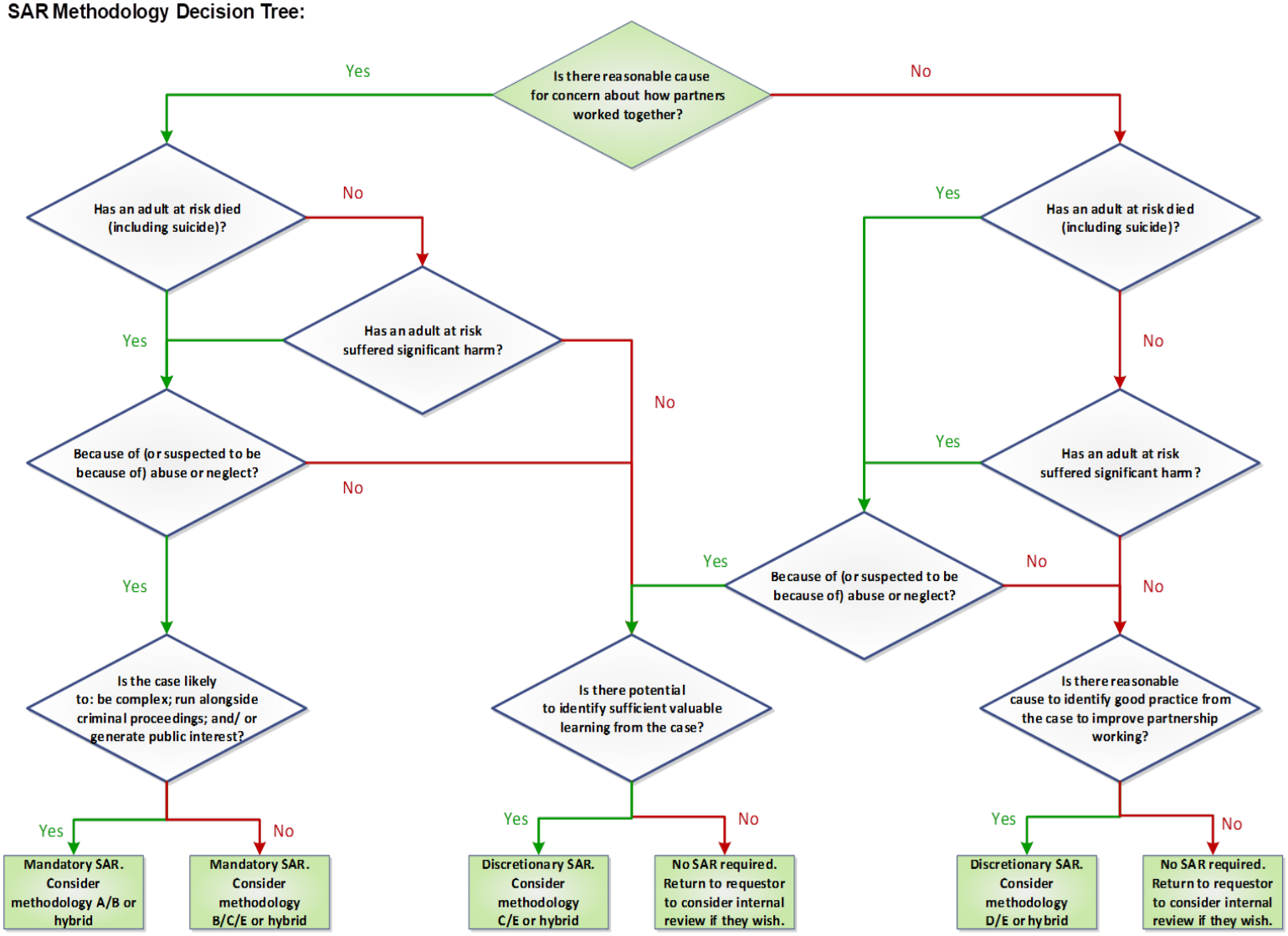
	This model may be suitable for SARs with a very specific focus and timeframe.
7 Consideration of other Statutory Reviews on their conclusion, for SARs These might be PSIRF process or MHHRs or DHRs	Where another statutory or regulatory review has already identified learning; and where the individual referred to also meets criteria for a SAR, there is no need to recommission more work. A SAR in such a case will be delivered using a model of identifying an independent Panel Chair to review the existing published statutory review with partners and make enquiries about any other agency involvement, considering further learning via a SAR Panel (and possibly learning review event) process. This would be a proportionate response.
8 Thematic SAR/ Review or reviews including more than one individual	When two or more individuals meet the criteria for a SAR to be commissioned and there are similar themes, then a thematic review can be considered for all cases to identify and disseminate learning.

Appendix 3 SAR Process



Appendix 4 – SAR Methodologies

SAR Methodology Decision Tree:



NB With thanks to Richmond and Wandsworth SAB

Safeguarding Adult Review (SAR) Referral Form.

Please provide the details requested below to enable members of the SAR Subgroup to make a proportionate decision as to whether this case meets the SAR criteria as set out in the Care Act 2014.

Professional requesting SAR.

Name	
Job Title	
Organisation	
Email	
Telephone number	

Other named professional (if appropriate).

Name	
Job Title	
Organisation	
Email	
Telephone number	

The Care Act (2014) states that SABs 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 concern that partner agencies could have worked more effectively to protect the adult, or, if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Individual's details.

Name	
Date of Birth	
Date of Death *(If applicable)*	
NHS Number *(if known)*	
Address	
GP Surgery *(if known)*	
Ethnic Origin	
Gender Identity	
Family / next of kin / advocate / representative details.	

Health and social care / or other presenting needs.

Details of SAR referral.

Outline of referral. ***Please detail the incident / rationale for requesting a SAR / rationale for delay in referral (if appropriate).***

Evidence of the individual's needs for care and support. ***Please detail in the box below.***

Evidence of the individual's experience or risk of abuse, harm or neglect. ***Please detail in the box below.***

Evidence of multi-agency involvement / working (include positive practice or concerns in this area). ***Please detail in the box below.***

Please list all agencies and contact names and details of those involved in the individual's care and support.

Please list details of any known statutory or other reviews ongoing or proposed in relation to this individual.

Any other relevant information.

Please send all SAR referrals forms to the Business Manager for the Safeguarding Adults Board.

- For Bournemouth, Christchurch & Poole referrals, send to: glynis.greenslade@bcpcouncil.gov.uk
- For Dorset referrals, send to: claire.hughes@bcpcouncil.gov.uk

SAR Subgroup Decision

Date of SAR Subgroup	

Decision of SAR Subgroup ***Include if the referral meets the criteria for SAR and decision of the subgroup.***

Professional updating SAR subgroup decision	
Job Role	
Organisation	
Date	