Nottingham City Safeguarding Adults Board

Nottinghamshire Safeguarding Adults Board
Stop abuse and neglect

Nottingham City & County Safeguarding Adults Board SAR Policy Procedure.

January 2025

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Safeguarding Adults Review Process

1. Criteria

A SAB must undertake reviews of cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

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

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

(b) condition 1 or 2 is met.

1.1 Condition 1 is met if—

(a) the adult has died, and

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

1.2 Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

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

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "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".

2 Referral of a Case to the Safeguarding Adults Review Subgroup

2.1 A referral to the relevant Safeguarding Adults Review Subgroup (SARSG) can be made by any organisation, individuals such as the coroner or members of the public; however, this must be with the agreement of their Nottingham City Safeguarding Adults Board (NCSAB) / Nottinghamshire Safeguarding Adults Board (NSAB) representative. If the agency making the referral does not have a Board member, then the referral must be discussed with and agreed by the Safeguarding Adults lead in that organisation.

2.2 Partner organisations making a referral for a SAR have a responsibility to quality assure the referral prior to sending it through to the NCSAB / NSAB and to compare it to the criteria for SARs detailed at 1.1 above.

2.3 SAR referrals should be made without any delay that may arise from operating pressures and partners should promote and explain the purpose of a SAR's to inform their own organisational workforce.

2.4 Referrals should be made on the agreed referral form and sent to the appropriate NCSAB / NSAB Business Office by e-mail in a secure format depending on where the abuse occurred.

2.5 For NCSAB (City): Ncsafeguardingadultsboard@nottinghamcity.gov.uk for referrals for adults in Nottingham City.

2.6 For NSAB (County): safeguarding1.adults@nottscc.gov.uk for referrals for adults in Nottinghamshire.

2.7 In Nottingham City only, the Board Manager or SARSG chair will review the referral within one week of receiving it and consider whether it appears that the SAR criteria have been met. Where the referral does not appear to meet the criteria, the SAR subgroup chair or Board Manager will write to the NCSAB Independent Chair (and the Board member of the referring organisation) to inform them that a SAR referral has been received but is not considered to meet the criteria, including the reasons why. If the referring agency is unhappy with this decision, they should raise this with the SARSG chair in the first instance (and refer to the Board's escalation process). If the NCSAB Independent Chair considers that it does or may meet the criteria, s/he will give reasons why in writing within 7 days and require the steps in 2.7 onwards to be followed.

2.8 Where the case appears to meet the criteria for a SAR, information will be requested from all NCSAB / NSAB Members and any other agencies known to be involved with the adult and their family prior to consideration at the SARSG to enable robust decision making. This will be undertaken using the Information Gathering form, which will be sent to the organisation's representative by e-mail in a secure format. Partners will be given a minimum of four weeks to respond.

2.9 In Nottingham City and County, the Board Manager will co-ordinate meetings every 6 weeks. Alongside the initial extra-ordinary multi-agency SARSG meeting within six weeks of receiving the referral, to map out the initial information.

2.10 Where partner agencies have concerns about an adult at risk but are unsure of other agency involvement and/or whether SAR criteria are met, in the first instance they should make a Safeguarding Referral to the Nottingham City Safeguarding Team, or the Nottinghamshire MASH. Adult Social Care will make enquiries as needed and this will include considering whether a SAR referral is required.

3 Decisions Whether to Initiate a Safeguarding Adult Review

3.1 In Nottingham City:

- After the Information Gathering forms (Appendix 2) have been received, an extra-ordinary meeting will be convened within six weeks of receiving the referral, to complete a detailed mapping of what was known by agencies. The authors of the Information Gathering forms (Appendix 2), as well as the members of the SAR Subgroup (often the authors of the Information Gathering forms), should be invited to the extra-ordinary meeting to map out the key practice episodes, as well as to recommend to the Board Independent Chair whether or not a SAR is required.

- The responsibility for chairing the extra-ordinary meeting sits with the Chair of the SAR Subgroup, who may decide to nominate another member of the SAR subgroup (for example if there is an agency represented on the SAR subgroup which had minimal contact with the subject of the referral).

- The mapping exercise may identify gaps that lead to requests for further information in addition to the Appendix 2s and/or information from additional agencies not identified in the original referral. Where further information is sought, a second extra-ordinary meeting may be required to review the additional information and feed into the mapping exercise This should take place within six weeks of the initial extra-ordinary meeting having been held.

- The purpose of the mapping exercise is to clearly identify what was known by the agencies involved, to identify any gaps and to inform the terms of reference to be drawn up at the planning stage. It is not the primary purpose of the mapping exercise to identify the learning, but some learning may emerge during the process. In some cases it may be that a detailed mapping exercise indicates that a full review is in fact, not required.

- As part of the mapping exercise, the Board Manager will consult the regional SAR database to determine whether there have been reviews with similar themes, which could inform the planning process.

- The extra-ordinary meeting should conclude with a recommendation to the Independent Chair, based on the mapping exercise, and after full consideration of the SAR criteria laid out in s.44 of the Care Act, as to whether or not a SAR is required.

- In normal circumstances, the Board Manager will support the chair with the facilitation of the extra-ordinary meeting and will provide the main link to the Independent Chair.

In exceptional circumstances, (e.g. where the Board Manager is unavailable) the SAR Subgroup should consider nominating a member of the subgroup to provide this link.

- The outcome of the extra-ordinary meeting will be shared with the Independent Chair who, in turn, will consider the information gathered before making a final decision about initiating a SAR. It is not expected that the Independent Chair will disagree with the conclusion reached at the extra-ordinary meeting and it anticipated that discussion between the respective Chairs would resolve any difference of opinion. Once agreement to proceed with a SAR has been reached, the Board manager will inform the Board as soon as is practicable about the decision.

- If the recommendation from the extra-ordinary meeting is that a SAR is <u>not</u> required, the Chair of the subgroup will write to the Independent Chair (and the board member of the referring organisation) to inform them (using Appendix 3). The Board Manager will inform in writing all other partner agencies who contributed to the mapping exercise.

- If the recommendation from the extra-ordinary meeting is that a SAR is required, the Chair of the subgroup will write to the Independent Chair to recommend that the SAR is initiated (using Appendix 3).

3.2 In Nottinghamshire County:
The SAR SG will consider if a mandatory SAR (meeting the threshold outlined in section 1 criteria) or a non-mandatory/ discretionary SAR (where the SARSG determine value to promote effective learning and improvement action to prevent future deaths or serious harm occurring).

3.3 In Nottingham City and Nottinghamshire County:

The SAR Subgroup is responsible for making a recommendation to the NCSAB / NSAB Independent Chair on whether or not to commission a SAR. Once an agreed recommendation has been made by the SARSG, this will be forwarded to the NCSAB / NSAB Independent Chair, on the agreed form, for a decision whether to complete a SAR. The decision by the NCSAB / NSAB Independent Chair will be communicated to the SARSG within 7 days of the recommendation being sent to the Independent Chair.

3.4 In Nottingham and Nottinghamshire, the Board covering the area where the abuse occurred will normally be responsible for undertaking the SAR. However, where it is felt that it would be more be more beneficial to learning for the Board where the adult normally resided/resides to lead to commission a review, the Independent Chairs of NSAB and NCASB should discuss and agree the most appropriate board to undertake the work**.**

4 Commissioning a Review

4.1 The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and

friends of adults who have died or been seriously abused or neglected. The SARSG should agree the most relevant and proportionate type of review. Where a case specific panel is convened, the panel responsible for deciding the review methodology with input from the independent reviewer is not required, this would be decided by the SAR subgroup.

4.2 An Independent Reviewer / Chair should be appointed to lead the review. They should be suitably qualified / experienced to lead the SAR in the way required. It is expected that the Independent Reviewer/Chair/Author will have appropriate skills and experience to address the terms of reference (see 1.6 below). This should include:

- strong leadership and ability to motivate others;
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- collaborative problem-solving experience and knowledge of participative approaches;
- good analytic skills and ability to manage qualitative data and write good quality reports;
- safeguarding knowledge;
- Inclined to promote an open, reflective learning culture;

As part of commissioning a reviewer, it should be agreed as early in the process as possible whether an executive summary will be required.

4.3 The type of review initiated will determine the level of governance required, and whether a separate standing panel is necessary will depend on the complexity of the case. This will be agreed by the SARSG as part of the Terms of Reference and the type of abuse and neglect that has taken place will be clearly identified in the Terms of Reference at this stage. Where a panel is required, an Independent Chair may be appointed. The Independent Chair may be the same person as the Independent Reviewer or may be a member of the SARSG if they are from a partner agency who has no / minimal involvement with the subject(s) of the review.

4.4 Where there is a case specific Panel, the Terms of Reference should consider:

- Who will be on the panel? It is suggested that where IMRs are requested, the panel could be formed of the IMR authors
- Who will chair the panel?
- What will be expected of the panel?
- How many times the panel will meet?
- How often the case specific panel will report back to the SAR subgroup
- What the panel is accountable for, and what the SAR subgroup is accountable for
- How will duplication of tasks be avoided?

4.5 Where there is not a case specific Panel the Terms of Reference should consider:

- What other agencies need to contribute to the review (not usually represented on the Subgroup)
- Will extra-ordinary subgroup meetings be needed?

- As the review progresses, if it becomes more complicated than initially anticipated, a panel can be convened at any point during the process.
- How will the review be chaired and who will be responsible for the detailed scrutiny of the information?
- How SAR subgroup members will keep separate the detailed scrutiny from the quality assurance role

[For further information about the roles required during a review, please see appendix one.]

Once it has been agreed that the criteria for a SAR is met, the board manager and SAR subgroup chair will take the following actions:

- Develop the terms of reference, including a proposed methodology

- Identify the specific skill sets required to complete the review and add these to the scoring matrix
- Develop the 'expression of interest form' and circulate through the Business Manager Network or send directly to known lead reviewers to give them opportunity to apply.
- once applications are received, we have the SAR subgroup reviewing applicants against the scoring matrix.
- Consideration to whether the independent reviewer has any real or perceived conflict of interest.
- The independent reviewer evidencing the most appropriate skills and experience, balanced against availability and cost will be offered the review.
- Following confirmation, the board manager will:
    - Prepare contract
    - Prepare Trade Supplier Request
    - Complete IR35 off payroll working
    - Submit CSO exemption
    - Request insurance details
    - Complete due diligence check
    - Confirmation letter to lead reviewer

Upon receiving the signed contract, the board manager will ensure all relevant documents pertaining to the case are accessible to the independent reviewer.

Quality Assurance

All types of reviews should:

- Be proportionate to the circumstances of the case
- Focus on potential learning and establish and explain the reasons why the events occurred as they did
- Fully involve practitioners and enable them to contribute their perspectives without fear of being blamed for actions they took in good faith
- Give adults and/or their advocates a voice about how professionals and services can better protect vulnerable adults in the future
- Invite families, including surviving children, to contribute to the reviews
- Provide an analysis of systemic or underlying reasons why actions were taken or not in respect of matters covered by the report

- Improve service responses for all by developing a coordinated multi-agency approach to ensure concerns are identified and responded to effectively at the earliest opportunity
- Contain findings and provide recommendations of practical value to organisations and professionals
- Be written in plain English

5 Principles of Safeguarding Adults Reviews

5.1 All Safeguarding Adults Reviews will reflect the six safeguarding principles as set out in the NCSAB / NSAB multi-agency procedures. In addition, SARs undertaken in Nottingham and Nottinghamshire will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;

- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;

- Partners have a duty to cooperate in the conduct of SARs, and there is an expectation to produce a briefing explaining what SARs are and relevant learning to embed in practice .

- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;

- Ensure families and/or individuals are invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.

    - Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
    - Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
    - Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
    - Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
    - Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to meetings or panels;
    - Make use of relevant research and case evidence to inform the findings of the review;
    - Identify what actions are required to develop practice;
    - Include the publication of a SAR Report (or executive summary);

- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

6 Terms of Reference (ToR)

6.1 The SARSG is responsible for developing Terms of Reference for the review. There will need to be due regard to any protected characteristics as defined in the 2010 Equality Act. The SARSG should discuss any risk of unconscious bias in the approach outlined by the ToR.

6.2 In Nottingham & Nottinghamshire where a recommendation is made for a SAR to be undertaken, an extra-ordinary SAR subgroup will be convened to plan the SAR and develop the Terms of Reference. The details from the mapping exercise will be used to inform the Terms of Reference.

6.3 There should be the ability to amend these prior to the review beginning to include details of the Independent Reviewer / Chair, and any changes agree with the Independent Reviewer. It should be noted that it is a requirement of the Care Act to publish SAR terms of reference.

6.4 Themes from regional and national analysis of SARs should be considered for inclusion in Terms of Reference where relevant depending on the type of review. For example, the London SAB SAR analysis Paper identifies the following four themes, which may provide a helpful framework

- The Quality of Direct Practice with the individual
- Organisational Factors which influence how practitioners work
- Inter-professional and interagency practice
- The SAB's interagency governance role

Where relevant the Terms of Reference should also ensure that reviewers draw out findings, which have national implications, for example where they relate to the social, economic or political context.

7 Agency Information

7.1 A decision on the use of Individual Management Reviews (IMR), chronology or other agency report submission will be made on a case-by-case basis; and be dependent on the review method identified. In some cases, they may not be used at all; in others, they may be requested from organisations with relevant and significant involvement with the adult and their family. If an organisation had only minimal involvement with the family and this was not connected to the Terms of Reference for the review, consideration will be given to the requirements for them to complete a background report or just a chronology.

7.2 It is the responsibility of individual agencies to identify an appropriate report author, taking into consideration whether a particular skill set is required, and quality assure information provided as part of reviews prior to submission, ensuring that it provides adequate information and reflects the terms of reference.

7.3 The assumption is that the agency report / IMR author will be independent of the line management of the case, to avoid any potential conflict of interest, which may later arise. In extenuating circumstances, where this is not possible, the SAR subgroup should decide how this will be managed.

7.4 Ownership of any information provided as part of a SAR will normally lie with the relevant SAB; however, this should be agreed and stated in the terms of reference.

7.5 If a request for this information is subsequently made by a third party, there should be a discussion between the agency who provided the information and the Independent Chair to agree if the information should be shared. It should be noted that the Information Commissioners Office has previously concluded (FS50368110, FS50628708) that where it is stated in a review's terms of reference that information provided by agencies is owned by a safeguarding board, there is no requirement under the Freedom of Information Act 2000 to provide this information to the third party. This is because safeguarding boards are statutory bodies and not public bodies; however, this does not mean that the request should always be refused.

8 Information sharing / consent and the engagement of family

8.1 Clarity on the legislative framework for sharing information to make a decision about whether a case meets the criteria for a SAR and to undertake the SAR will be included in the initial request for information sent to agencies. The statutory Care Act Guidance 2014 sets out a requirement for persons and bodies to comply with a request for information for the purposes of the SAB functions.

8.2 With regard to the issue of consent, the SARSG will consider:

- At what point the subject / parents / families will be informed of the SAR (specific family members will be identified and agreement about who will be contacted, when and by whom);
- Issues in relation to consent and Public Interest including the impact of criminal, coronial and care proceedings on the ability to liaise with the family;
- The requirement for advocacy for the subject;
- Inclusion of their views of the support provided to them by organisations;
- Inclusion of their views on the findings of the review;
- Feedback to inform them of the progress of the SAR,
- The impact of publication of the SAR Report. This needs to be considered at the outset of the process and reviewed as appropriate
- The agreements must be clearly recorded within the Terms of Reference.

9 Timescale for Safeguarding Adult Review Completion

9.1 The SAB will aim for completion of the Safeguarding Adult Review within six months of initiating the review. If this is not possible (e.g. because of potential prejudice to related court proceedings), every effort should be made while the Safeguarding Adult Review is in progress to:

- Capture points from the case about improvements needed; and
- Take any corrective action identified as required.

10 SAR Report and Publication

10.1 A good Safeguarding Adults Review Report will consist of:

- Provide a sound analysis of what happened in the case, and why; and what action needs to be taken to prevent a recurrence, if possible;
- Be written in plain English and in a way that can be easily understood by professionals and the public alike;
- Be updated for publication following the conclusion of any criminal or coronial processes and the contribution of the subject and/or family members;
- Identify key learning to enable the formulation of appropriate recommendations and a strategic action plan by the SARSG.
- Consider any protected characteristics as defined in the 2010 Equality Act as part of the report narrative and ensure the need to recognise unconscious bias.

10.2. The final published Report or Executive Summary will be usually fully anonymised to ensure the subject is not identifiable.

10.3. Ratification of the SAR Report will be undertaken through the NCSAB / NSAB structure and agreed in the review timetable within the terms of reference.

10.4. The SARSG will be responsible for agreeing the SAR Recommendations and Board Action Plan, along with the SAR Report prior to presentation to the NCSAB / NSAB Strategic Board.

10.5 In order to provide transparency and to support national sharing of lessons learnt All published reviews are to be shared with the library. There is a presumption that reviews of cases meeting the Safeguarding Adult Review criteria will result in a readily accessible published report (which may take the form of an executive summary or a suitably redacted overview report depending upon the circumstances of the case) on the SAB's website. This will be determined on a case-by-case basis. If published, it will remain on the website for a minimum of 12 months and maximum of 7 years in line with the retention procedure and data protection impact assessment. Thereafter this will be available on request.

10.6 The fact that the SAR report/executive summary may be published must be taken into consideration at the outset and throughout the process, with reports written in such a way that publication will not be likely to harm the welfare of any adults involved in the case and consideration given on how best to manage the impact of publication on those affected by the case. The SAB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders. Publication will be carefully planned depending on any parallel processes (criminal and coronial) and family contributions.

10.7 The SAB will publish, either as part of the final Safeguarding Adult Review report or in a separate document, information about:

- Actions already taken in response to the review findings;
- The impact these actions have had on improving services; and
- What more will be done.

10.8 A **media strategy** will be developed to support publication and the management of any media enquiries.

10 Learning & Improvement

11.1 The SARSG will be responsible for the monitoring of the combined inter-agency and Strategic Action Plans.

11.2 Organisations will measure and evaluate the impact of actions within their own agencies and provided evidence to the SAB.

11.3 The SAB should include the findings from any SAR in its Annual Report and what action 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. All documentation the SAB receives from registered providers which is relevant to CQC's regulatory functions will be given to the CQC on CQC's request.

11.4 Themes that potentially have connotations on a national scale and require a wider discussion can be progressed though the Escalation protocol with agreement of the SARSG and Independent Chair (National Escalation Protocol for Issues from Safeguarding Adults Reviews from Safeguarding Adult Boards | Local Government Association)

12 Parallel Processes

12.1 The impact and timing of any parallel processes on the review should be acknowledged. Police advice must be sought in relation to the potential impact of the SAR and engagement of practitioners / managers involved in the case where there is a criminal investigation or the potential for one. Liaison with the Coroner must be undertaken throughout the SAR when there is potential for an inquest;

12.2 Where other SAB areas have been involved in the provision of services to the family, liaison between SAB Managers will be undertaken to request relevant contribution to the review. In some circumstances (for example where there is significant involvement of two or more SAB's) consideration should be given to the most appropriate way to manage the SAR;

12.3 It is a statutory requirement for victims of domestic homicide to be subject to a Domestic Abuse Related Death Reviews. Where there are concerns in respect of safeguarding adults, consideration should be given to the criteria for a SAR, a Domestic Abuse Related Death Review, and the most appropriate means to achieve the maximum learning. This may include consideration of how to manage parallel reviews and how to minimise duplication of work.

12.4 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a child Serious Case Review (SCR) and a Domestic Abuse Related Death Review. Where such reviews may be relevant to SAR

(e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHR's and SCRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case, for example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

12.5 It may be helpful when running a SAR and Domestic Abuse Related Death Reviews or child SCR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroner's inquiry, and/or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the NCASPB/NSAB Manager/Officer to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

13 Organisational abuse

13.1 Organisational abuse within care settings may be in the form of neglect and/or poor professional practice. It may take the form of isolated incidents of poor practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems.

13.2 In cases where the criteria for a SAR are met as a result of the care received within a care setting, consideration will need to be given to whether this is an indication of organisational abuse and the risks posed to all residents.

13.3 This may result in one SAR being undertaken relating to a number of individuals. Where this is the case, views of all families/carers and/or individuals should still be considered as part of the review.

Appendix 1

Description of possible roles required

It is recognised that some agencies may not be able to identify separate people for each stage in the process. **Agencies are responsible for deciding who the most appropriate person for each stage is, and where there is duplication of roles, how this will be managed.**

Initial information gathering/screening:

- Identifying whether the person was known to your agency
- Identifying any reasonable causes for concern about how the SAB, organisations, or other persons worked together to safeguard the adult
- Any gaps or omissions
- Information gathered to be shared with SAR subgroup member (where agency is represented on the SAR subgroup), presented by the author, or presented by the Board Manager.
- Where a SAR is initiated, the author will be required to attend an initial mapping session to identify key practice episodes, learning and areas for the review to investigate to inform the ToR.

Agency report/ IMR author (or single agency chronology & appraisal)

- Ideally a trained IMR author or experienced report writer, able to produce chronology and analysis and/or full IMR/agency report and present findings
- be prepared to be scrutinised and challenged
- Accountable for declaring any conflict of interests at either the beginning or that may emerge as progresses.

Where there is a case specific panel - SAR Panel member

- Responsible for checking the drafts of the report for accuracy, challenging and validating content before presenting to the SAR subgroup for quality assurance
- Responsible for contributing to the progress of the SAR, including the detailed work examining practice episodes, identifying learning, working with the author
- This could be the same person as the IMR author, but they must be capable of objectively analysing practice, policy and systems.
- The SAR panel member must keep in contact with their organisation's SAR subgroup representative (where applicable) to keep them informed of the progress of the review, of emerging learning and themes.
- The content of the SAR should not be a surprise to the SAR subgroup member when a draft is first presented to the SAR subgroup.

SAR Panel chair

- Must be a person experienced in SAR processes.
- Locally due to resource constraints wherever possible this will be an experienced member of the SAR subgroup
- Responsible for close adherence to the process
- Responsible for escalating any risks to the plan to the SAR subgroup.

- They will be responsible for managing the relationship with the independent author, supported by the Board Manager.
- They will be responsible for ensuring that the author keeps to the ToR, and where learning emerges that indicates the ToR need reviewing will escalate this to the SAR subgroup.

SAR subgroup

- The SAR subgroup are responsible for the Quality Assurance of the report and for checking and challenging the findings.
- SAR subgroup takes priority over the panel.
- The SAR subgroup should review a draft of the overview report, but SAR subgroup members must ensure that they have been kept informed by the panel member/IMR author of findings emerging from the review and should not be surprised by anything at the point of first reading a draft. This is to minimise the amount of redrafting required after first sight of the report.
- SAR subgroup members must ensure that IMR authors/panel members understand the SAR processes.
- SAR subgroup members are also responsible for keeping their Board members informed of progress, learning and findings of the review so that they are aware of emerging issues before the report is sent to the Board for ratification.
- SAR subgroup members should keep the relevant manager in their organisation informed.
- The Chair of the SAR subgroup will escalate to the NCSAB independent chair where there are concerns about how the process is working in practice.

Board

- The Board is responsible for final ratification of the SAR report.
- Board members should ensure that colleagues delegated to other roles are aware of their responsibilities and manage any conflicts of interest that arise where colleagues are required to take more than one role.
- Board members should ensure that their subgroup member keeps them informed of the progress of the review, emerging themes and learning. The content of the review should not be a surprise at the point at which it is presented to board for ratification.
- Where Board members are concerned about the progress of the review, these should be escalated to the Independent Chair.

Nottingham City Safeguarding Adults Board

Nottinghamshire Safeguarding Adults Board
Stop abuse and neglect

A 'SAR' Guide for Families & Loved Ones

What is a Safeguarding Adults Review?
Safeguarding Adult Boards (SAB) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that agencies could have worked more effectively to protect the adult. A SAB must also arrange a SAR if an adult in its area has not died, but it is known or suspected that the adult has experienced serious abuse or neglect.

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.

Purpose of the SAR
SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again**.**

Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal and disciplinary procedures, employment law and professional regulatory bodies such as the Care Quality Commission (CQC), the Nursing and Midwifery Council and the Health and Care Professions Council for example.

SARs are completely separate from other investigations that may be occurring, for example by the Police, CQC or Coroner, although they can still take account of the findings of those investigations.

Who is involved in a SAR and what happens?
Whilst Safeguarding Adults Boards lead SARs, they commission consultants who are called 'independent authors', who have no connection with any of the organisations or personnel involved in the review.

The organisations involved in the care and treatment of the person under review must co-operate with the SAR. Typically, these include agencies who are already board members, such as adult social care, the police, health services (including Integrated Care Board and hospitals), probation, the DWP and local fire and rescue and ambulance services. However, agencies who are not board members, such as care homes, home care providers and housing associations, may also be involved.

Once a SAR has been agreed, an independent author is commissioned, and terms of reference and key lines of enquiry are established. Next, requests for information, including chronologies of events and documentation are made to the agencies involved. Sometimes, interviews or learning events are held where all the key individuals involved gather together to discuss what happened in detail. Finally, the independent author begins writing their report, consulting on and sharing drafts until a final version is agreed.

Your involvement
It is important that the Safeguarding Adults Boards hear the voice of the person who has been abused or neglected, as well as those voices of family members and loved ones if the person has died because of abuse.

If you are invited to take part in a SAR, the independent author will ask you to share your thoughts on what happened leading up to, including and after the event under review. However, the decision to take part in a SAR is entirely yours and if you do not wish to do so, your decision will be respected.

Dependent upon circumstances, and what you feel most comfortable with, you can be involved in several ways. Typically, these include in writing, over the phone, via a teleconference call (such as 'Zoom') or face-to-face. Discussion will be informal but professional and can last as long as needed, though typically 1 to 2 hours is enough. You can also be consulted more than once.

What happens to the information you share?
The information you share will help the independent author build a comprehensive picture of what happened before the death or abuse or neglect occurred and will help to shape the findings and recommendations of the report. Your contribution can be anonymous or you can decide to be identified in the report. Any copies of pictures or documents you provide will only be reproduced with your agreement.

It is important to remember that the independent author has final say over the contents of the report and they might not include all that you tell them or agree with your view of what happened. You should consider this carefully when deciding whether to participate in a SAR.

How long do Safeguarding Adults Reviews take?
A SAR should be completed within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required. If there are ongoing court proceedings the report typically will not be published until court proceedings have concluded.

What happens when the SAR is completed?
Once the independent author has finished their report – and you will be shown a draft version beforehand to comment upon – [it is usually published on the board's public website. However, where there is sensitive information that could adversely affect others (for example, if there are children involved), a redacted summary may be published, or the decision made not to publish a report at all.] [a summary of the

report will be published on the SAB's website, which will not contain any sensitive information but will include the recommendations made in the full report.]

Once the report is published, the board draws up a plan so that all agencies involved ensure that the lessons learnt are implemented and monitored until completed. Change can be slow and some recommendations involve requests to make changes at a national level, which are not always possible. SARs are a legal report but their recommendations are not, and agencies do not have to agree to implement all of the changes listed.

Further Information

If you have any further questions about SARs, please contact

- Nottingham City Safeguarding Adults Board at ncsafeguardingadultsboard@nottinghamcity.gov.uk
- Nottinghamshire Safeguarding Adults Board at
- Safeguarding1.adults@nottscc.gov.uk

Safeguarding Adults Review: Impact Record (IR)

*add agency name

Agencies should begin and submit this form within six months of the SAR action plan completion date. This tool captures organisational change, learning and impact upon partner agencies, staff and those they work with. Impact can be positive or negative, intended or unintended.

Name of agency:

1. **Internal actions agreed following 'initial return'; IMR report; SAR learning event etc**.

List of any organisational changes agreed prior to / in addition to SAR recommendations	Description of organisational changes made or planned
Training Programme Implementation	
Training Courses	
E-Learning	
Shared Learning	

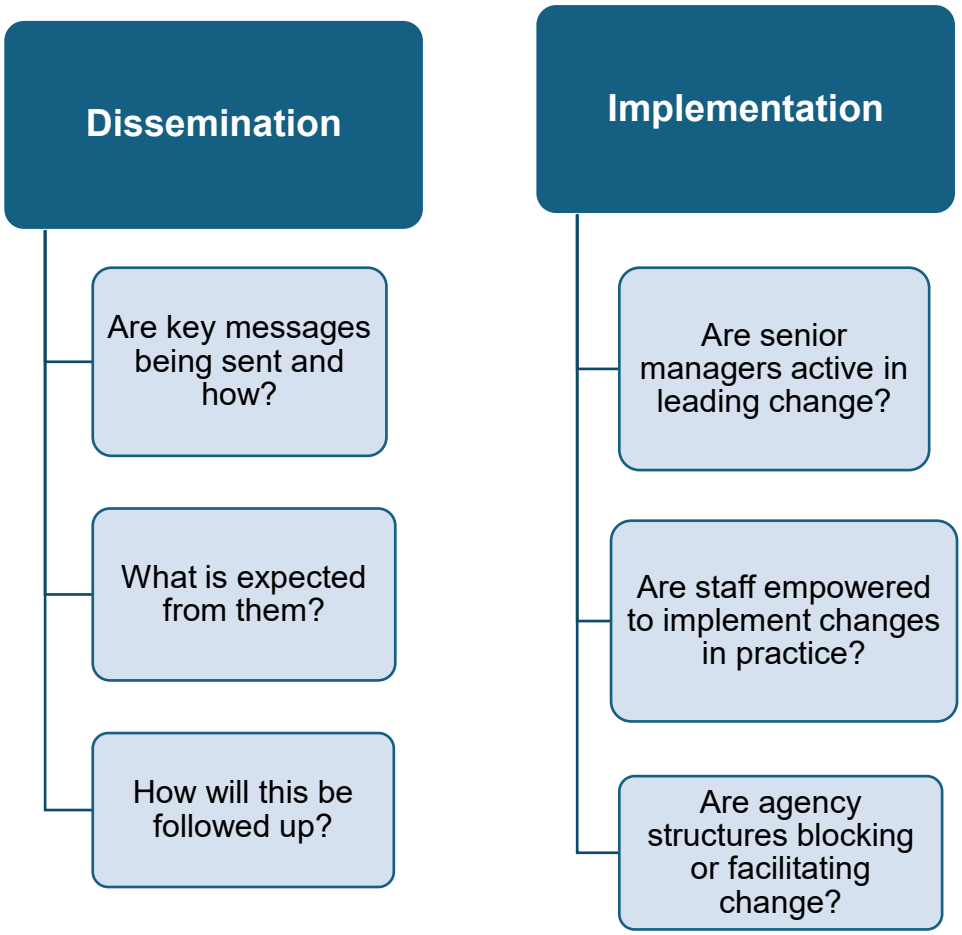
2. **Is this an issue identified previously by a SAR or other formal or statutory review? (If 'yes', discuss with board manager)**

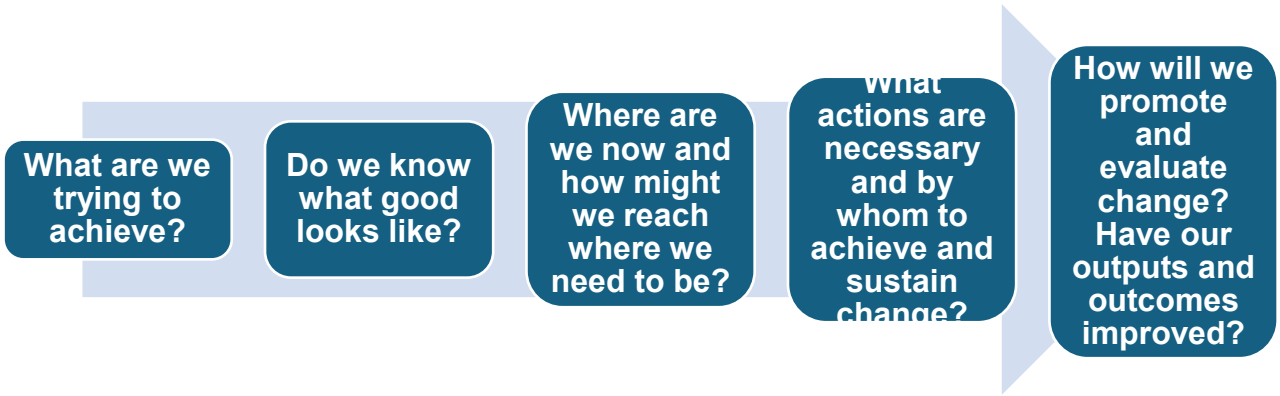
○ Yes ◉ No

3. **SAR report recommendations and actions from SAR Action plan specific to agency:**

List of SAR report recommendations relevant to agency	List of actions from SAR Action plan specific to agency

Before continuing this form, it may be helpful to consider these three models in relation to your agency:





Partner reactions	• Partners can see change in your agency's adult safeguarding practice
Changing attitudes	• Staff attitudes towards adult safeguarding practice improve
Knowledge and skill acquisition	• Staff knowledge & skills in relation to adult safeguarding improves, as does understanding of assessment, intervention and roles in the adult safeguarding process
Changes in practice	• Workforce competence increases, preventative work occurs, referral quality improves
Changes in organisational behaviour	• Organisational improvements in procedure and culture are evident and recordable
Benefits to service users and carers	• Improvements in service user and carer wellbeing are visible and measurable

2. **Impact of SAR report recommendations and Action plan actions**

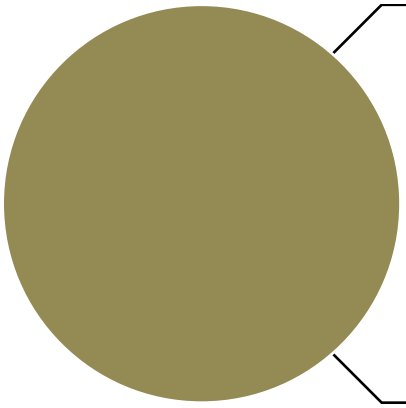
Impact upon staff practice; policy & procedure; organisational structure; service users & others	Description and evidence of impact

3. **Audits**
   Please detail any case audits or exercises undertaken that evidence embedded learning and / or that revised policies and procedures / organisational changes have had a positive impact:

4. **Overall 'Impact of Learning on Outcomes Rating' (ILOR) rating (see appendix 1 for more information)**

GOLD	Evidence that learning is impacting key outcomes for adults at risk
SILVER	Evidence that learning is changing practice, attitudes and/or culture
BRONZE	Evidence that learning has been disseminated through the organisation and/or professional networks to the relevant workforce

Rating Agreed	☐ **Gold** ☒ **Silver** ☐ **Bronze** ☐ **Not met (see appendix 1 for more information)**
Evidence to Support the Rating (not already mentioned above): .	
Additional activity planned (with the aim of improving the rating) ▪	
Timescales for additional activity / Anticipated completion date	
Name of person completing the ILOR assessment	
Sign off / Senior manager agreeing the rating	
Submission date	
If you have a case study / citizen feedback or other material which evidences outcomes achieved, or that you think could be of benefit to other partnership organisations, please email safeguardingpartnerships@nottinghamcity.gov.uk, ensuring that no identifying information is included	

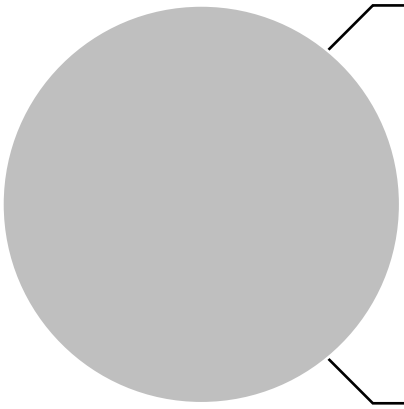


BRONZE

Evidence that learning has been disseminated through the organisation or professional networks.

Local and national learning has been disseminated throughout the workforce.

Training has been delivered at the appropriate level to the organisation's workforce, either through specific training sessions or review and update of current training courses.



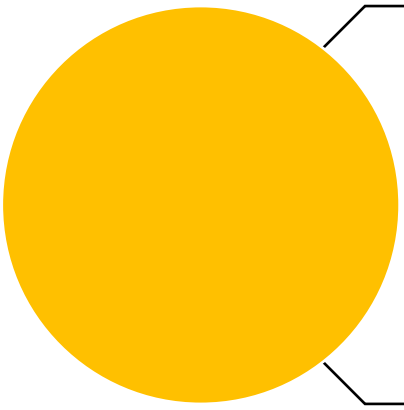
SILVER

Evidence that learning is changing practice, attitudes and/or culture.

As above and...

Existing work processes have been modified to take account of the changes the learning has brought about.

There is an increasingly embedded awareness of the learning within the workforce, and a growing understanding of the changes the learning has brought about.



GOLD

Evidence learning is impacting key outcomes for adults at risk.

As above and...

Learning is thoroughly embedded within the workforce and understanding evident in regular practice.

Policies & procedures have been re-written to take account of changes the learning has introduced.

Evidence is available from adults at risk about the postive impact the learning has made to them.

Appendix 1

Cross-Boundary Safeguarding Adult Reviews

Guidance for Safeguarding Adults Boards Business Units in the East Midlands

This guidance has been based and adapted from the North East SAR Champions Network Cross-Boundary guidance.

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Introduction

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult with care and support needs in its area dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is reasonable cause for concern that its partner agencies could have worked together more effectively to protect the adult.

There is growing recognition nationally that where a SAR involves more than one SAB (a cross-boundary SAR), the 'Host SAB' (where the adult has been seriously harmed or died), may not always be best placed to co-ordinate the SAR as the adult may not be known or have minimal involvement with services in its area. Therefore, the Host SAB may identify learning that is not wholly relevant or applicable to its partners and would be seeking assurance from agencies that are not within its partnership.

For people with no fixed abode or those who are more transient and travel regularly across local authority boundaries, or individuals who self-neglect and the neglect essentially moves with the person. It can pose some challenges for SABs as the place of residency, location of abuse/neglect and location of death may all be different areas.

The SCIE SAR Quality Markers state: *"In a review involving other SABs, have you achieved clarity and agreement from the outset about who leads the SAR (e.g. area for whom most learning is likely to emerge) and governance arrangements?"*

ADASS' Guidance for Out of Area Safeguarding Arrangements 2016 (currently under review) states: *"If a SAR is being considered, the SAB of the Host authority (where the abuse has taken place) will be responsible for liaising with all those involved, including the SAB in any placing authorities. The relevant Board Managers and Independent Chairs should agree how the SAR will be undertaken. Boards and organisations should cooperate across borders and requests for the provision of information should be responded to as a priority..."*

Purpose

To provide guidance and a set of key principles for Business Units to agree a consistent, proportionate and practical approach to co-ordinating SARs that involve multiple SABs.

This guidance should be used in conjunction with the SAB's own SAR Policy and Procedures, Information Sharing Agreements and SCIE's SAR Quality Markers.

This guidance can be used flexibly and is case dependent. It is not intended to be a definitive approach.

Key considerations

1. Where did the person live?
2. Where did the abuse/neglect take place?
3. Where were the services who provided support from?[1]
4. Who is the learning most applicable to?

SAB Business Unit guidance

SAR notification is received and it is identified that another SAB is involved:

1. The Host SAB will follow its initial screening process at this stage, as appropriate.
2. The Host SAB's Business Unit to notify other SAB(s) of the case.
3. If needed, the Host SAB can arrange a virtual meeting with other SAB area(s) Business Manager(s) and/or SAR Co-ordinator(s) to discuss:

    - The key considerations listed above.
    - Any further information required to decide whether the Notification progresses to the next stage (for consideration of a SAR). Any Notifications screened out at this stage should be recorded with clear rationale.
    - If the Notification will progress, to agree scoping dates for information requested.
    - Who will be asked for information?
    - Agreed deadline for agencies to submit information.
    - Who should be invited to the Host SAB's[2] SAR Sub-Group/Panel Meeting? (SAB Business Units to consider what agencies are involved and who needs to attend at the appropriate senior level to make a recommendation in line with its own governance requirements). Attendance may be case specific. These meetings should take place virtually wherever possible, to make it easier for colleagues from other areas to attend.
    - Based on the information known at the time, and considering the four key principles above, agree who will be the Lead SAB (i.e. which SAB is likely to benefit most from any learning identified).[3]

[1] To also take into consideration whether there is a health or social care commissioner and/or placing authority.
[2] Unless it is agreed at this stage that the Host SAB will not be the Lead SAB.
[3] If an agreement cannot be reached between Business Units at this stage as to who the Lead SAB will be, a discussion should be held between the relevant SAB Chairs to determine next steps. If agreement is not reached between the SAB Chairs, a joint SAR Sub-Group/Committee meeting should be convened to ensure that a joint recommendation is made to the relevant SAB Chairs. If agreement is still not reached,

Actions from the Business Unit meeting should be clearly recorded and shared with relevant Business Units, so it is clear who has responsibility, with clear deadlines.

Note: For high profile/urgent cases, the Host SAB may need to act swiftly to address any immediate safeguarding issues and, therefore, internal SAR/Safeguarding processes may need to take priority.

Information sharing/gathering

Information should be shared in accordance with the Data Protection Act 2018 and GDPR regulations. It is the responsibility of recipients to ensure confidentiality is maintained and information deleted when it is no longer needed.

Once a Lead SAB has been agreed, they should be responsible for maintaining all records in line with their own Information Governance policies and procedures.

When invites are sent to out of area colleagues, Business Units will make clear the purpose of the meeting and in what capacity they are invited. The supporting SAB will support in ensuring contact details are correct and the right people are invited.

The Lead SAB should request information (using their own templates) from local and out of area agencies with assistance from supporting SAB(s).

SAR Sub-Group/Panel Meeting

- All SABs should be represented (in line with their own governance requirements).
- The Lead SAB Business Unit should use their own information gathering forms and processes at this stage.
- All colleagues attending should have the opportunity to ask questions and contribute to discussions.
- Collectively a recommendation should be made as to whether the criteria for a Safeguarding Adult Review is met:

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a SAR Sub-Group/Panel/Committee Meeting should be convened by the Host SAB; this will allow further discussion informed by additional information gathered to determine which SAB is likely to benefit most from the learning from the SAR.

- If the Lead SAB has already been agreed prior to the meeting, the Lead Business Unit should follow its own processes for a Recommendation for consideration to its SAB Chair and inform the supporting SAB Business Unit(s) and partner agencies of the outcome.
- At this stage it may not be clear as to who will benefit most from the learning. For example, if there are multiple SABs involved, and the individual was quite transient across geographical boundaries. SABs may also want to take into account proportionality, practical issues linked to geographical locations (such as staff who may need to travel for meetings), where family live, previous learning from SARs. If an agreement for the Lead SAB has not yet been reached, the group should discuss which SAB is likely to benefit most from the learning and jointly make a recommendation as to who the 'Lead SAB' should be. A joint recommendation should be made to the relevant SAB Chairs for discussion and to agree any potential commissioning implications[4]. SAB Chairs should communicate their decision to Business Managers/SAR Coordinators. The SAB who coordinated the meeting should communicate the decision to all who attended the meeting.

- The Business Unit who coordinated the meeting should follow their own internal process for informing organisations (including out of area agencies) who provided information for the Sub-Group to consider.

Ultimately, it is for individual SABs to consider whether the case meets the SAR criteria when applied to its own SAB partners and to ensure clear rationale for any decisions made.

Next steps

- The Lead SAB should be responsible for coordinating and overseeing all aspects of the SAR, with support from other SAB Business Units where appropriate.
- Where required, any commissioning decisions in respect of the SAR will be discussed and agreed by the SAB Chairs.
- Where the adult or family lives in another Local Authority area to the Lead SAB, a practical approach should be taken to consider which professional is best placed to liaise with family (considering geographical location, who knows them best and any potential conflict of interest, e.g., where families have raised concerns/complaints about a specific agency). In addition, considering how the adult/family prefers to be communicated with. The supporting SAB would only liaise with the adult/family in exceptional circumstances where all other options by the Lead SAB to engage with them have been explored, or in exceptional circumstances where it is deemed to be more appropriate for the supporting SAB to liaise with family as they already have a positive and established relationship with the adult/family.

[4] If the Independent Chairs are unable to agree on next steps, in the first instance a meeting should be held with the Independent Chairs, SAR Sub-Group Chairs, Business Managers and SAR Coordinators (where applicable). In the unlikely event that agreement cannot be reached, consideration will be given to escalate the case to the Regional SAB Chairs Network for discussion, independent views and agree next steps. These steps for escalation are intended as a guide and can be used flexibly and on a case by case basis. Thought should be given regarding timeliness of decision making.

- Supporting SAB agencies involved will be invited to contribute as part of the SAR process.

Terms of reference

- Lead SAB to liaise with supporting SAB Business Unit(s) to invite key partners to draft the Terms of Reference.
- The terms of reference should:

    - Clearly identify the Lead SAB, who will coordinate the SAR and oversee the action plan.
    - Clearly identify supporting SABs who will assist with information sharing and holding their own organisations to account.
    - Contain a Methodology for the SAR.
    - Detail the focus/KLOEs for the SAR (considering previous learning from each SAB) and what each SAB area wants to achieve from the SAR.
    - Detail clear outputs (i.e., how will the learning be published? Would this be via a report, learning briefing, training resource etc.)
    - Identify which SAB will publish the learning
    - Contain clear responsibilities regarding engagement with the adult(s)/families

Ongoing communication

The Lead SAB should provide updates to the supporting SAB Business Units at key points throughout the SAR process. Minutes of meetings can be shared with Business Units for information where appropriate.

Recommendations

At the point in which the recommendations are being drafted, the Lead SAB should liaise with supporting SAB Business Units so that key individuals can be involved. This is helpful to consider learning from previous SARs or work that is already taking place linked to learning from the SAR.

Legal checks

Depending on the nature of the case, some SABs may wish to share the final draft report with their legal teams. The Lead SAB should make contact with supporting SABs once the report is in its final draft so that any legal checks can be carried out.

Sign off

When the report is in its final draft (and checked by Legal Teams if required). The Lead SAB should enquire with supporting SABs the best way to seek approval from supporting SAB members. This may be an email circulation, or a presentation delivered by the Independent Reviewer. For more complex SARs an Extraordinary Board meeting with key partners from all SABs may need to be convened.

Timescales for seeking approval from other Boards will need to be factored into any communication with the adult/family.

Note: SABs may have different processes for when to share the report with the adult/family therefore this may also have an impact on timescales for publication.

Publication

Once the SAR has been formally approved by all SABs, the Lead SAB should liaise with supporting SABs to coordinate a media strategy or pre-emptive 'if asked' press statement prior to publication with relevant Communications Leads.

A realistic timescale should be given for publication, and the adult/family will be informed of this date.

The Lead SAB should publish the report on its website (unless there are special circumstances where it has been agreed by SABs not to publish). Supporting SABs can include a weblink on their website to the Lead SAB's webpage.

Action plan

The Lead SAB should liaise with supporting SABs to seek appropriate representation/ written feedback to assist in drafting the action plan. Depending on learning that has already taken place in a SAB area, actions may differ for each SAB to meet a recommendation.

The Lead SAB should be responsible for overseeing the action plan and collating evidence. The supporting SABs should liaise with partners to meet the requirements of the action plan within

their SAB area and feed this information into the Lead SAB. Each SAB will be responsible for holding their own organisations to account.

Annual report

The Lead SAB should count the case as part of their data around SARs. Supporting SABs may wish to reference any cases where they were involved but it will not be included as part of their SAR data.

East Midlands document approval

Safeguarding Adults Board area	Date agreed
Derbyshire	June 2025
Leicester	September 2025
Northamptonshire	October 2025
Nottingham City	December 2025
Derby	October 2025
Lincolnshire	March 2026
Nottinghamshire	October 2025
Leicestershire and Rutland	December 2025

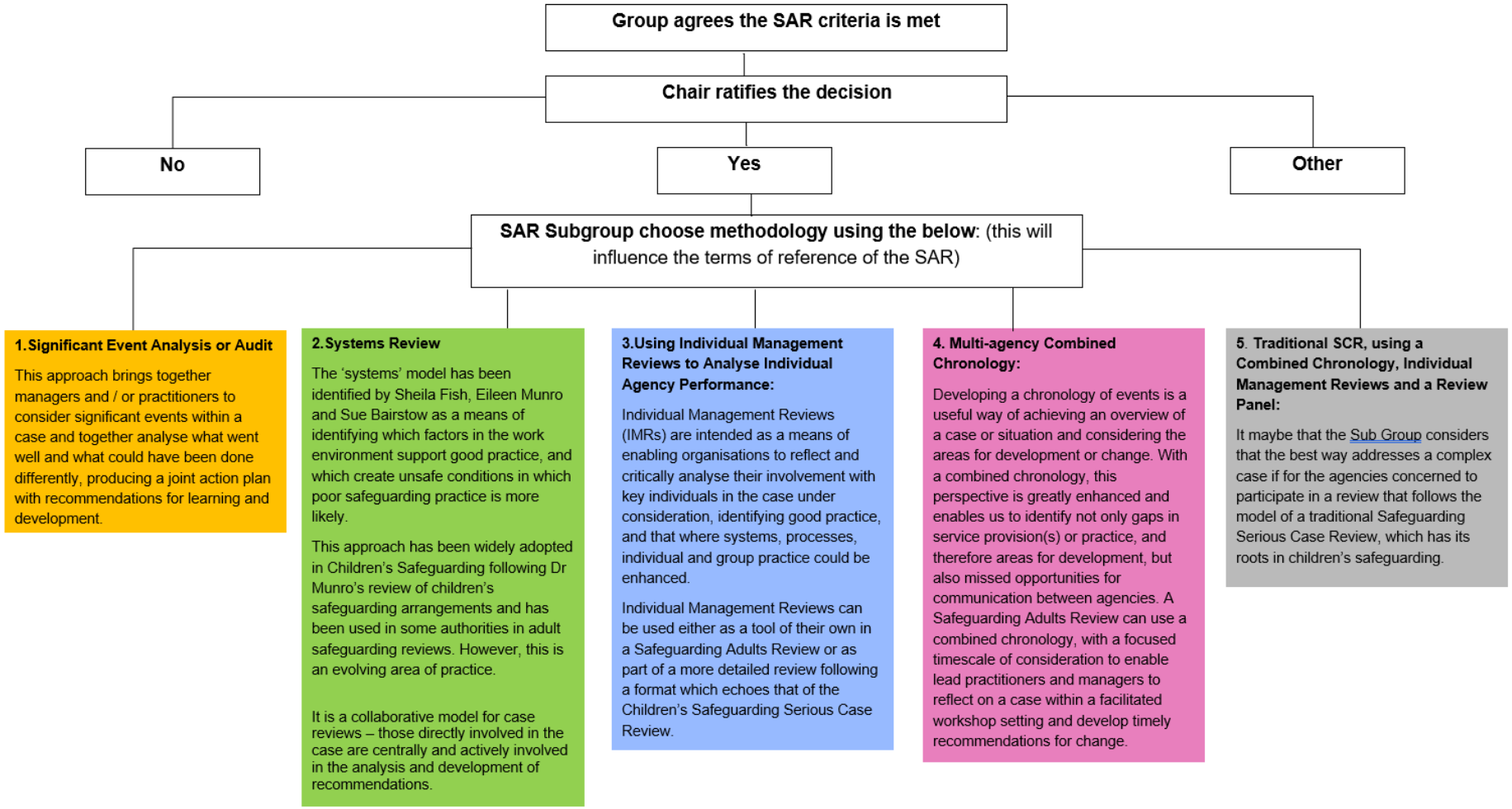
Document version control

The Derbyshire Safeguarding Adults Board holds the primary copy of this guidance, email derbyshiresab@derbyshire.gov.uk

Version	Date	Updates made
1.0	07/10/2025	Not applicable as this is the first version.

-End of document-

SAR Methodology Tree



***None of the 5 options above have a requirement for a commissioned independent reviewer and the possibility of an individual with a sufficient level of capacity and impartiality from within the local system for a lighter touch review should be considered in the first instance.**

1.Significant Event Analysis or Audit
 	
This approach 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 action 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:
	  ○ How could things have been different?
	  ○ What can be learned from what happened?
	  ○ What has been learned?
	  ○ What has been changed or actioned?

2.Systems Review The 'systems' model has been identified by Sheila Fish, Eileen Munro and Sue Bairstow as 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. This approach has been widely adopted in Children's Safeguarding following Dr Munro's review of children's safeguarding arrangements and has been used in some authorities in adult safeguarding reviews. However, this is an evolving area of practice. It is a collaborative model for case reviews – those directly involved in the case are centrally and actively 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; timeframes:(completion, 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 BSAB; frontline 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 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 presented to BSAB, agree dissemination of learning and monitoring of implementation • Follow up event to consider action plan recommendations • On-going monitoring via the BSAB.

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, identifying good practice, and that where systems, processes, individual and group practice could be enhanced. Individual Management Reviews can be used either as a tool of their own in a Safeguarding Adults Review or as part of a more detailed review following a format which echoes that of the Children's Safeguarding Serious Case Review.	Individual Management Reviews 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-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model. Most popular methodology used – more information in Appendix 3 of the SAR Toolkit.
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, this perspective is greatly enhanced and enables us to identify not only gaps in service provision(s) or practice, and therefore areas for development, but also missed opportunities for communication between agencies. A Safeguarding Adults Review can 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 using the Chronolator Online Tool. This enables a group of agencies to identify gaps in communication, shared decision-making and risk assessment. As such, the 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-based review, or a review involving a multi-agency review panel, whether as part of a one-off workshop or a review following the traditional Serious Case Review model.

5. **Traditional SCR, using a Combined Chronology, Individual Management Reviews and a Review Panel:** It maybe that the Sub Group considers that the best way addresses a complex case if for the agencies concerned to participate in a review that follows the model of a traditional Safeguarding Serious Case Review, which has its roots in children's safeguarding.	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 Sub Group will give very careful consideration to any added 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 that they are managed within a clear governance framework.