West of Berkshire
Safeguarding Adults Board
Reading, West Berkshire & Wokingham

Safeguarding Adult Review (SAR) Process

September 2020
Version 1

Date due for Review: September 2022

Contents

1. Section 1, SAR Criteria

1.1. Purpose

The aim of this document is to streamline the process for carrying out a Safeguarding Adults Review (SAR) for the West of Berkshire Safeguarding Adults Partnership Board (SAB) members, managers and practitioners, and to clarify the different roles and responsibilities of individual agencies, the SAB and its Subgroups.

The SAB follows the Pan Berkshire Safeguarding Policies and Procedures and the SAR policy can be found here: https://www.berkshiresafeguardingadults.co.uk/2-adult-safeguarding-policy/29-safeguarding-adult-reviews-sars/

1.2. Context

SARS are about learning lessons for the future. They will make sure that Safeguarding Adults SABs (SABs) get the full picture of what went wrong, so that all organisations involved can improve their practice.

In developing these guiding principles, the West of Berkshire Safeguarding Adults SAB seek to ensure that:

- We have processes for learning and reviewing that are flexible and proportionate and open to professional and public challenge.
- We can determine locally what type of review is appropriate dependent on the nature of the case and the agencies involved.
- A culture of transparency is created that provides for a positive shared learning culture.

This document sets out the SABs' expectations for a Safeguarding Adult Review of a serious case, within which there is room for professional judgement and flexibility.

1.3. Legislation

Section 44 of the Care Act puts a duty upon the Safeguarding Adults SAB (SAB) to 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:

I. There is reasonable cause for concern about how the SAB, its members or other persons with relevant functions worked together to safeguard the adult,

and

II. The adult has died, and 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).

Or

III. If the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Under the Care Act each member of the SAB must co-operate in and contribute to the carrying out of a review with a view to identifying the lessons to be learnt from the adult's case and applying those lessons to future cases.

1.4. Circumstances to consider a multi-agency response

The SAB may also conduct a review in other circumstances, for instance:

- In circumstances involving the abuse and neglect of a large number of adults at risk or by multiple perpetrators. With regard to institutional abuse there must be clear evidence that concerns regarding the standards of care mean that all or the majority of service users are at risk.
- Where a case gives rise to concerns about the way in which local professionals and services work together to safeguard adults at risk.
- Any case where there are public interest issues and where the SAB agrees there is a specific need to carry out a review.

1.5. Guiding Principles

The following principles should be observed. The degree of relevance will depend upon the nature of the case and type of review:

a) **Urgency** – Agencies should take action immediately and follow this through as quickly as possible.
b) **Accountability and engagement** – the SAB will hold individual agencies to account at each stage of the process.
c) **Impartiality** – Those conducting reviews should not have been directly concerned with the adult at risk or the family.
d) **Thoroughness** – All important factors should be considered and there should be an opportunity for all those involved to contribute.
e) **Inclusion** - The review should include, and support, the victim, family and staff throughout the process as appropriate.
f) **Links** - should be made to other investigations and the criminal justice system.
g) **Openness** – The review should be a transparent and honest appraisal of practice. Publication will be considered on a case by case basis.
h) **Confidentiality** – The review will operate within a framework of confidentiality, paying due regard to the balance of individuals' rights and the public interest.
i) **Co-operation** – Each SAB should provide a framework to ensure close collaboration between all the agencies involved.
j) **Resolution and Learning** – Any new knowledge or lessons learned should be shared and disseminated on a multi-agency basis, with identified issues promptly actioned by the agencies concerned. Additionally, it is intended that they will be used to develop and promote practice regionally.
k) **Review** – Action should be taken to ensure recommendations have been implemented.

1.6. Quality Indicators for SAR's

The SAB will refer SCIE'[1]s SAR Quality Marker checklist (See Appendix 1), throughout the process. The quality markers are as follows:

- **Quality Marker 1:** Referral, the case is referred for a SAR consideration with an appropriate rationale and in a timely manner
- **Quality Marker 2:** Decision making- what kind of SAR, factors related to the case AND the local context inform decision making about whether a SAR is needed and initial thinking about its size and scope.
- **Quality Marker 3:** Informing the person, their family or other important network, the person, relevant family members, friends and network are told what the SAR is for, how it will work and the parameters, and are treated with respect.
- **Quality Marker 4:** Clarity of purpose, the SAB is clear and transparent, from the outset, that the SAR is a statutory process, with the purpose of organisational learning and improvement, and acknowledges any factors that complicate this goal
- **Quality Marker 5:** Commissioning, decisions about the precise form and focus of the SAR to be commissioned take into account a range of case and contextual factors in order to make the SAR proportionate to the potential for learning and improvement. Decisions are made with input from the SAB Chair and members and in conjunction with the reviewers.
- **Quality Marker 6:** Governance, the SAR Review achieves the requirement for independence AND ownership of the findings by the SAB and member agencies
- **Quality Marker 7:** Management of the process, The SAR is effectively managed. It runs smoothly, is concluded in a timely manner and within available resources.
- **Quality Marker 8:** Parallel processes, where there are parallel processes the SAR is managed to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and relevant family members.
- **Quality Marker 9:** Assembling information, the SAR gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors.

[1] https://www.scie.org.uk/safeguarding/adults/reviews/care-act#assurance

- **Quality Marker 10:** Practitioners Involvement, the SAR enables practitioners and managers to have a constructive experience of taking part in the review.
- **Quality Marker 11:** Involvement of the person and relevant family members and network, the SAR is informed by the person and relevant family and network members' knowledge and experiences relevant to the period under review.
- **Quality Marker 12:** Analysis, the SAR analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard adults.
- **Quality Marker 13:** The Report, identifies clearly and succinctly the analysis and findings of the SAR, while keeping details of the person to a minimum. Findings reflect the causal factors and systems learning the analysis has evidenced.
- **Quality Marker 14**: Improvement Action, the SAB enables robust, informed discussion and agreement by agencies of what action should be taken in response to the SAR.
- **Quality Marker 15:** SAB Written Response, in development
- **Quality Marker 16:** Publication, in development
- **Quality Marker 17:** Implementation and Evaluation, in development

2. Section 2, The SAR Process

2.1. Step 1, Submitting a SAR notification

Anyone can refer a case for consideration for a SAR. Each agency will have its own decision-making processes for such reviews, but it is expected that all agencies will ensure that decisions are made as expeditiously as possible.

Complete the notification report template (Appendix 2) and send securely to the SAB Business Manager. Instead of using this template to notify the Panel, Thames Valley Police officers will use a Primary Assessment Chronology (Appendix 3) and must receive authorisation from senior officers before submitting the notification.

Agencies are be expected to include the Safeguarding Team in the relevant Local Authority when submitting notifications. In the event of any reason they haven't the SAB Business Manager is to be informed the reasons why. It is an expectation that the Director for Adult Health and Social Care Services (DASS) for the host local authority is informed by the notifying agency of the notification.

The Business Manager will forward all notifications for consideration to the Independent Chair of the SAB and SAR Panel Chair to confirm if the notification meets the SAR Panel criteria. If the SAB Independent Chair, SAR Panel Chair and SAB Business Manager agree that the notification meets the SAR criteria the notification will be discussed at the next suitable SAR Panel. If it is agreed that the notification does not meet the criteria the SAB Business Manager will go back to the person who completed the notification to seek further clarification on reasons why the notifying person thinks the SAR criteria is met and a final decision will be made.

Once a SAR notification is received an Individual SAR Decisions and Actions Tracking Tool (Appendix 4) will be created by the SAB Business Manager, in order to provide a clear audit trail in regard to the SAR decision making process.

2.2. Step 2, Presentation at SAR Panel and Decision

Once approved, the case will be presented to the SAR Panel by the agency that raised the notification. All members of the SAR Panel will be asked to bring relevant information pertinent to the cases put forward for consideration. This is so that the Panel can make an informed decision on the next steps, preventing any avoidable delay.

If appropriate if the person who completed the SAR Panel notification is not a SAR Panel member, they will be invited to attend SAR Panel to present the notification.

The Panel will:

- Review the report and decide whether the case meets the criteria for a SAR
- Agree what type of review is proportionate and will offer the best learning
- Set the Terms of Reference
- Agree a timeframe for reporting back
- Manage a SAR Tracking document to track key decisions (Appendix 2)

SAR Panel meetings will be held monthly, with additional panel meetings called as necessary.

SAR Panel membership and quoracy is set within the SAR Panel Terms of Reference (Appendix 5).

2.3. Step 3, Feedback

The decision is fed back to the agency who initiated the notification.

The individual whose case is subject to the SAR, or most appropriate representative will be informed that a SAR will be undertaken (see sections 3.2 and 3.3 on support for the adult at risk and support for the family/significant others)**.**

Agencies who will be involved in the review will be informed, who will inform relevant staff members of the SAR (see section 3.4 staff involvement).

The Care Quality Commission (CQC) is informed of any review for a regulated provider.

2.4. Step 4, Commencement of Review

Lead agency commences the Safeguarding Adult Review as per the agreed Terms of Reference, with the support of the Business Manager. The Business Manager will agree appropriate administrative support with the lead agency.

Commissioning an author, the lead Local Authority will be responsible for commissioning an author for the SAR. The SAB Business Manager will support with the recruitment process of the author. The SAR Panel can allocate the task of author to members of the partnership if deemed appropriate. Authors must be approved by the SAR Panel Chair and Business Manager, and the process and rationale for how and why an author was assigned to SAR is clearly documented in the Individual SAR Decisions and Actions Tracking Tool (Appendix 4).

If an author is commissioned outside of the partnership the host Local Authority are to provide the author with a contract to deliver the SAR as set out within the terms of reference. The contract is to include Data storage requirements that complies with the Data Protection Act. See section 3.7 disposal and declaration of disposal of Records for the review.

The Business Manager will request information required from agencies as set out in the Terms of Reference. See section 3.1 on supply of information.

The lead agency will provide a progress update every SAR Panel meeting.

Independent scrutiny must be evidence in the process via the SAR panel meetings and minutes and if needed a meeting with the reviewer part way through.

2.5. Step 5, Final Report and Recommendations

Panel will review findings and identify multi-agency recommendations and sign off the report.

If there has been involvement from the individual or an advocate, the author will meet with them to discuss the report and add any feedback to the final version if appropriate. A copy of the report will not be left with the individuals as it remains property of the SAB.

Key stakeholders involved in the SAR will be provided with a copy of the report and will be informed of the date the SAR will go to the SAB for endorsement in order to prepare their organisations.

The final findings report, and recommendations will be presented to the SAB for consideration at the SAB meeting. The Independent Chair will call an exceptional SAB meeting or asked for virtual endorsement if required.

The SAB will consider if the SAR will be published and set any conditions regarding publication.

Prior to its publications, at no point must the SAR be shared outside of the SAB membership or key stakeholders, without the permission of the Business Manager.

2.6. Step 6, Action Plans

Once the findings report and recommendations are accepted by the SAB. The SAR Panel (or specific task group) will;

- Agree relevant actions and present these in an implementation plan which will be shared with the SAB and appropriate Subgroups
- Agree publication plan for the SAR

The implementation plan will be monitored by the SAB Subgroups and areas of risk reported to the SAB via the Subgroup Chairs.

Organisations are encouraged to devise individual action plans from learning from SARS.

2.7. Step 7 Monitoring and Review

All recommendations will be included in a learning from SAR/Audit implementation plan, to be kept up to date by the Business Manager.
A summary report on progress on the learning from SAR/Audit Implementation plan will be presented to each SAB.

Each agency involved in the SAR will be required to submit a Learning from SAR Quality Check (Appendix 9) to the Business Manager within of 3 months of the SAR endorsement to demonstrate how learning from the SAR has been embedded within their organisations.

2.8. Step 8, Sharing Learning

The Business manager will provide a summary learning document to be published on the website in conjunction with the lead LA which will be shared with partner agencies for dissemination and use in training.

Performance and Quality Subgroup will review and revise the self-assessment audit document on an annual basis to ensure it reflect findings from SAR's.

The Annual Report will report on SAR's carried out within the year and what agencies have done to deliver actions and embed learning.

The SAR, if published, will be uploaded to the SCIE SAR Library:
https://www.scie.org.uk/safeguarding/adults/reviews/library

3. SECTION 3, Important considerations for SARS

3.1. Supply of Information

It is important that organisations share information related to abuse or neglect with SABs.

The Care Act is clear that if a SAB requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the SAB. This is so any problems can be tackled quickly, and lessons can be learnt to prevent the same thing happening again.

Consideration should be given by those conducting a review to attend a Coroner's inquest.

3.2. Support for the Adult at Risk

All processes should engage the adult at risk and their carers and take account of their wishes. It is important that the adult at risk is informed that the purpose of this review is to understand how different agencies worked together in order to identify lessons so as to improve systems, practice and partnership working. And that it is not for a SAR to investigate how a death or serious incident happened or to apportion blame.

If the adult at risk has capacity or can be appropriately supported, they will be invited to contribute to the Review. It is important to support them to contribute their views if they wish. They should be informed of the Review and any findings shared with them. This is an inclusive process and support, including access to professional interpreters and accessible communication means, should be provided to overcome any communication barriers.

The SAR Panel when setting the Terms of Reference will consider how the adult at risk and/or advocate will be informed about the SAR taking into account how the communication may impact on them.

The adult at risk may need a worker and/or advocate to support them throughout the process and will need further contact as appropriate. This will include informing them of the Review and sharing the findings.

If the report needs to be shared with the adult at risk and/or advocate prior to publication, an agreement to be drawn up clarifying that the report cannot be shared, and that it must be destroyed within an agreed timeframe.

There is no obligation for the copies report to be shared with the adult at risk and/or advocate at any point during the process. This should be clearly communicated at the start of the process.

A leaflet can be found in Appendix 10, which should be provided when the adult at risk and/or advocate is informed that a SAR is to take place.

3.3. Support for the Family/Significant Others

If the adult at risk has capacity and gives consent for their family/significant others and other who have significant involvement in their lives to be involved with the review, or the person has passed away, then the family/significant others will be invited to contribute. It is important that the adult at risk is informed that the purpose of this review is to understand how different agencies worked together in order to identify lessons so as to improve systems, practice and partnership working. And that it is not for a SAR to investigate how a death or serious incident happened or to apportion blame.

It is important to support members of the family to contribute their views if they wish.

The SAR Panel when setting the Terms of Reference will consider how the family/significant other will be informed about the SAR taking into account how the communication may impact on them. The SAR Panel will consider the family dynamics when setting the terms of reference ensuring that all relevant family members have been invited to contribute to the process.

This is an inclusive process and support, including access to professional interpreters and accessible communication means, should be provided to overcome any communication barriers. The family may need a worker to support them through the process and will need further contact as appropriate. They should be informed of the review and any findings shared with them.

If the report needs to be shared with family/significant others prior to publication, an agreement will be drawn up clarifying that the report cannot be shared and must be destroyed within an agreed timeframe.

At the end of the process they should be given the opportunity to discuss the outcomes and their experience of the process, for example through a case conference.

There is no obligation for the copies report to be shared with the family/significant others at any point during the process. This should be clearly communicated at the start of the process.

A leaflet can be found in Appendix 10.

3.4. Involving staff through the process

As soon as a SAR has been agreed, staff that have had involvement should be notified of this decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff and their line managers. It should be made clear that the review process can be lengthy. It is important that all relevant members of agencies are given an opportunity to share their views on the case.

Agencies are responsible for ensuring staff are provided with emotional support. This support should be clearly identified and communicated to all staff involved. The death or serious injury of an adult at risk will have an impact on staff and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff involved to the team, organisation or workplace.

The purpose of a SAR is not to apportion blame to an individual agency but to learn lessons for future practice. It is important that this message is conveyed to staff. However, on occasion, concerns about an individual's practice may be raised through the review process and these concerns would be fed back to their agency through the SAR Chair. Any action, including disciplinary action as a result of this, would remain the responsibility of the individual agency.

Professionals should be asked their views about what, in their opinion, could have made a difference for the person or their family.

3.5. Accountability and Engagement

The SAB will hold individual agencies to account at each stage of the process: engagement in the review, inform practice developments and other management processes where relevant, and monitor effectiveness of the changes.

In practice this means to committing to attending meetings, contributing to developing the findings, make SAB aware of progress on developing and delivering action plans.

If there are multi-agency findings from the review, they should be shared with the SAB and partner agencies.

3.6. Links with other investigations, The Criminal Justice System and Domestic Homicide Reviews

SAR's are not enquiries into why an adult dies or who is to blame. These are matters for the Coroner's Court, Criminal Courts and employment procedures as appropriate. SARs are also not disciplinary proceedings and should therefore be conducted in a manner which facilitates learning. Appropriate arrangements must be made to support those staff involved.

It is acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents. There is an expectation that these will continue throughout the review process if any other issues are identified it is appropriate that these are dealt with.

The Domestic Homicide Review (DHR) process will be used instead when someone has been killed as a result of domestic violence and abuse. DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews can be found at this link:
https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

3.7. Disposal and declaration of disposal of Records for the review

Confidential storage arrangement during the review with the author should be established with the commissioner and once published the author should delate all records or return to the B/M in accordance with the author arrangements DATA protection and the Business Manager of the SAB can keep all record for the review.

3.8. Publication of SARS

The SAB will aim to publish all SARS in full, however this decision will be made on a case by case basis and maybe in the form of a learning summary or practice note.

4. SECTION 4, SAR Methodologies

A methodology for a SAR is to be agreed by the SAR Panel when setting the Terms of Reference. There is a possible danger of fitting the review to the methodology rather than the methodology to the review. Therefore, the SAR Panel can choose adapt methodologies to suite the objectives of the SAR.

Below is an outline of some of the review methods the SAR Panel may wish to consider. This list is not exhaustive.

4.1. Traditional Serious Case Review

All the agencies involved contribute to the review. The SAB will commission an overview report which brings together and analyses the findings of various reports from agencies in order to make recommendations for future action. An action plan is developed and the SAB and senior managers within relevant organisations make sure improvements are made. The report is written by an independent person.

4.2. SCIE Learning Together Review

Learning Together is based on a 'systems approach' which recognises that any worker's performance is a result both of their own skill and knowledge, and the systems (context) in which they work. It is a collaborative approach and appreciates the views of people from different agencies and professions.
It is a well-developed, recognised and tested systems approach to learning and improvement, as recommended by the Munro Review of Child Protection (2011) and Working Together to Safeguard Children (2013).

A Learning Together review**:**

- focuses on the child or adult affected;
- engages all of the agencies involved in the case;

- goes beyond identifying what happened, to explaining *why* it happened;
- generates new ideas about how to improve practice; and
- develops local skills and expertise.

The process helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.
https://www.scie.org.uk/training/safeguarding-reviews-audits/learning-together

4.3. Appreciative Inquiry (AI)

This is a strengths-based model, asking questions, that challenge and draw out a process that focuses on collaboration approach, valuing strengths within systems and organisations. Appreciative Inquiries can be known to include: discover, dream, design and defining stages to create learning.

4.4. Significant Incident Learning Process (SILP)

Developed by Paul Tudor, the SILP uses a similar approach to the SCIE Model. It is intended for reviewing cases which do not meet the criteria for traditional Serious Case Reviews, or for cases that meet the criteria, but would benefit from a more proportionate approach to obtain the best learning.

This approach encourages the engagement of frontline staff and first line managers in conjunction with SAB Members and / or other relevant professionals. The involvement of frontline staff and first line managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

Process:
The key agencies and professionals involved in the identified case will be invited to a half-day or full day event to examine the case together.

Rather than an IMR, agencies will provide chronologies of events, one facilitator will chair the event and another will write up the learning. An external facilitator may be used if the complexity of the case means it is necessary to do so.

This process will involve operational staff and their managers who would own their own summary of learning at the end of the process, leading to these being disseminated more quickly and at an operational level. A second event would take place to review how the agreed actions had been met and how the learning was disseminated within agencies. Finally the report is presented to the SAB for sign off.

4.5. Multi-agency Root Cause Analysis (RCA) or Serious Incident Requiring Investigation (SIRI)

An investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If we understand the contributory factors and causal factors - the Root Causes- of an incident or outcome, we can put in place corrective measures. By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. In this way we can prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided.

When things go wrong, it can be all too easy to look to apportion individual blame and fault. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Organisations should use their own SIRI procedures if this is deemed suitable. However special consideration should be given to involving Partner Organisations. During the first 72 hours of any incident these procedures should be followed in any case.

4.6. SAR in Rapid Time

A SAR In-Rapid-Time aims to have a turnaround time of 15 working days from set-up meeting, held after the decision has been made to progress with a review. An outline of the process is captured below. Standardised processes and templates support this speedy turn around. The process will be supported by remote meeting facilities and not require any face-to-face contact.

- Day 1, Set up meeting
- Day 2-7, Check agency records
- Day 8-11, Produce early analysis report to structure the discussion
- Day 11-12, Participants read the report in preparation
- Day 13, Structured multiagency discussion
- Day 14-15, Systems finding report

At the time writing, SCIE were in the process of:

- Producing guidance and templates for the SARs In Rapid Time process and outcomes
- Supporting familiarisation with the process with webinars, and remote support
- Liaising with SABs to enable the submission of SARs In Rapid Time reports to the national SAR library
- Routine collation of learning from SARs In Rapid Time submitted
- Producing and disseminating regular learning briefings

Refer to the SCIE website when considering the SAR in Rapid Time Approach:
https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/

4.7. Other Approaches

If the case does not reach the criteria for a SAR, other processes may facilitate learning and identify ways for organisations to improve working together. These approaches may also help determine whether the case meets the threshold for a SAR or be proportionate for the all or part of the SAR:

4.7.1. Case conference

There is particularly a place for a case conference at the end of the process.

4.7.2. Single Agency Management Reviews

It may be appropriate that reviews are undertaken by a single agency. Management Reviews are a critical analysis of that agency's management of the case, will identify lessons learnt and the actions needed to address them.

4.7.3. Multi-Agency Triaging Review

Following a safeguarding alert, a multi-agency triaging review may be called by any agency. Each organisation will produce a chronology of their involvement with the adult at risk, to be combined. A meeting of all relevant representatives from partner organisations will be called to discuss the case, with an appropriate person (such as the LA's Safeguarding Manager) as Chair. Decisions and actions will be recorded, including the need to share and embed learning into practice. A second meeting may be required to report on actions and review further information. The format can change dependent on the case.

4.7.4. Reflective Practice Session

The original participants in the case may review situations as part of a reflective practice session, chaired by the Safeguarding Adults Manager or other suitable person.

The findings and lessons learned from these approaches will be presented to the SAB in order to determine if a case should progress to a SAR.

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Appendix	Title	Link	Description
1	Appendix 1 - SCIE's SAR Quality Marker checklist	Appendix 1 - v1SAR Quality Markers 14 Jun	Quality Markers to be adhered to during the process.
2	Appendix 2 - Notification of a Case for Consideration	Appendix 2 - Notification of a Case	SAR Notification form
3	Appendix 3 - Domestic Homicide Review	Appendix 3 - Domestic Homicide Re	Notification form for Thames Valley Police only
4	Appendix 4 -Individual SAR Decisions and Actions Tracking Tool	Appendix 4 - Individual SAR Decis	SAR panel track progress and decisions made throughout the SAR
5	Appendix 5 – SAR Panel ToR September 2020	Appendix 5 - SAR Panel TOR Septembe	SAR Panel Terms of Reference
6	Appendix 6 – IMR Template	Appendix 6 - IMR Template.docx	IMR template that may be used by organisations to complete IMRs
7	Appendix 7 - Request for chronology information Letter Template	Appendix 7 - Request for chronology inform	Letter template for SAB to request information
8	Appendix 8 - SAR Chronology template	Appendix 8 - SAR Chronology templat	Chronology template
9	Appendix 9 - Learning from SAR Quality Check V.1.0	Appendix 9 - Learning from SAR C	To monitor SAR learning across the partnership
10	Appendix 10 – SAR Information Leaflet	Appendix 10 - SAR Information Leaflet V.1	To be given to individuals and/or family members if invited to contribute to the SAR