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

Safeguarding Adult Review (SAR) Process

July 2024
Version 2.3

Date due for Review: July 2026

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.

The 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). Reviews of this nature will be labelled a discretionary SAR and will be commissioned only when the SAR Panel are of the view that there is learning for the partnership that cannot be obtained through other learning processes.

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. 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.

1.5. Quality Indicators for SAR's

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

Setting up the review

Quality Marker 1: Referral, the case is referred for a SAR consideration with an appropriate rationale and in a timely manner.
Quality Marker 2: Factors related to the case and the local context inform decision making about whether a SAR is required and/or desired and initial thinking about its size and scope. The rationale for these decisions is clear, defensible, and reached in a timely fashion.
Quality Marker 3: Informing the person, members of their family and social 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 learning- focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities. Any factors that may complicate this goal are opening acknowledged.
Quality Marker 5: Strategic commissioning of the SAR takes into account a range of case and wider contextual factors to determine the right approach to identifying learning about what is facilitating or obstructing good practice and/or the progress of related improvement activities. Decisions are made by those with delegated responsibility in conjunction with the reviewers, and balance methodological rigor with the need to be proportionate.

Running the Review

Quality Marker 6: Governance, SAB governance arrangements for the SAR are sound, enabling defensible decision making, reliable over-sight and accountability regarding the SAR process, outputs and impact. The SAR achieves the requirement for independence and ownership of the findings by the SAB and member agencies and enables public accountability for learning and improvement.
Quality Marker 7: Management of the process, The SAR is effectively and considerately managed. It runs smoothly, is concluded in a timely manner and within available resources. The welfare of all participants is

[1] List of 15 Safeguarding Adult Reviews Quality Markers - SCIE

attended to. The process strives to help bring resolution to any tensions or conflicts between individuals or agencies as well as questions of families.

Quality Marker 8: Parallel processes, where there is parallel processes the SAR is managed with the cooperation and communication required 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 a sufficient range and quality of information and input, to determine the relevant objective facts, to 'stand in the shoes' and 'get inside the heads' of those involved and to grasp the way that single and multi-agency/professional practice is shaped both by work environments and conditions, and by social and organisational factors. The kinds of data assembled allows unique versus generalisable issues to be distinguished. The extent of, and methods for, data gathering are transparent and proportionate to the practical value of the SAR.

Quality Marker 10: Practitioners Involvement, the SAR is informed by the experiences and perspectives of practitioners and managers, as relevant to the precise form and focus of the SAR commissioned. The process enables practitioners and managers to have a constructive experience of taking part in the review that helps cultivate an open learning culture.

Quality Marker 11: Involvement of the person and relevant family members and network, The SAR is informed by the person, relevant members of their family and social network in terms of information they hold, their experiences and perspectives as relevant to the precise form and focus of the SAR commissioned. The process enables the individual and family to see how the SAR is designed to have impact and contribute to positive change.

Quality Marker 12: Analysis, the approach and methodology agreed for the SAR is used with optimum rigor within the size and scope of SAR commissioned. Analysis assumes a systems approach to safety and organisational reliability. It is anchored in relevant research and wider evidence base regarding effective clinical/professional practice and that of safety science. It draws on the full range of relevant information and input assembled, to evaluate and explain professional practice in the case(s) or the responses to earlier learning. Conclusions are of practical value, evidencing the wider learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date. There is transparency about any methodological limitations and the implications for the comprehensiveness or level of confidence in the analysis and findings, outputs, action and Impact.

<u>Outputs, action and impact</u>

Quality Marker 13: The Report the length and detail of the SAR report match the size and scope of what was commissioned. At minimum, it makes visible, in a clear, succinct manner, the systemic risks to the reliability of single and multi-agency safeguarding work that the SAR analysis has evidenced, in order to have practical value in directing improvement actions. It is written with a view to being published. Details of the person are included as judged necessary to illuminate the learning and/or in line with the wishes of the individual or their family.

Quality Marker 14: Publication and dissemination, activities are timely and publicise the key systemic risks identified through the SAR, as well as features supporting high reliability of single and multi-agency working relevant to safeguarding. Compelling and engaging means of circulating the findings are used, adapted as necessary for different operational and strategic audiences. Decisions about what, when, how and for how long to publish and disseminate findings are made with sensitive consideration of the wishes and impact on the person, family and other families; professionals who participated are kept informed and supported as needed. Publication and dissemination foster active responsibility and public accountability for addressing barriers identified to good practice or progressing improvement work.

Quality Marker 15: Improvement actions agreed in response to the SAR set ambitious goals, seeking to align the motivations of different stakeholders, bringing partners together in new ways and foster collaborative working. Actions are integrated, wherever possible, with wider strategic improvement activity, plans and priorities, led locally, regionally or nationally. Evaluation of impact is designed from the start, supported by a logic model or similar, using measures that demonstrate whether the underlying causes of systemic risks identified have been addressed. The SAB maintains a public record of findings, actions and commentary to enable public accountability.

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.

To submit a SAR for consideration The SAR notification of a case for consideration (Appendix 2) must be completed in full and sent securely to the SAB Business Manager.

Those submitting the SAR notification should:

- Carefully consider the Care Act S44, SAR Criteria before making a notification and that this is clearly demonstrated in the notification.
- Where appropriate discuss the notification with partners before submission, so that the notification provides as much information about the: reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.

The Business Manager will forward all SAR notifications for consideration to the SAR Panel Chair to confirm if the notification meets the SAR Panel criteria. If the SAR Panel Chair and SAB Business Manager agree that the SAR 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 Tracking Tool (Appendix 3) will be created by the SAB Business Manager, to provide a clear audit trail in regard to the SAR 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 the SAR Tracking Tool to track key decisions (Appendix 3)

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 4).

2.3. Step 3, Feedback

The decision is fed back to the agency who initiated the notification by their SAR Panel Representative or the SAB Business Manager if the agency does not have a rep on the panel.

The individual whose case is subject to the SAR, or most appropriate representative will be informed that a SAR will be undertaken at the most appropriate time within the process (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) will not be routinely informed of all commissioned SARs, they will be informed if they are required to contribute to the process or the SAR Panel are of the view they need to be informed.

2.4. Step 4, Commencement of Review

The SAR Panel will agree a timetable for the review. The administrative support will be provided by the SAB Business Manager. The SAR Panel will decide if the SAR should be undertaken by a member of the partnership or an external author.

If commissioning an author, the lead Local Authority (where the abuse/or neglect occurred) will be responsible. The SAB Business Manager will support with the recruitment process of the author. Authors must be approved by the SAR Panel Chair, SAB Business Manager, and lead Local Authority SAR Panel representative. The process and rationale for how and why an author was assigned to SAR is clearly documented in the Individual SAR Tracking Tool (Appendix 3).

If an author is commissioned outside of the partnership the lead 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 SAB Business Manager will request information required from agencies as set out in the Terms of Reference or for the SAR Panel to set the Terms of Reference section 3.1 on supply of information.

The lead Local Authority will provide a progress update every SAR Panel meeting, until the SAR is endorsed by the SAB.

Independent scrutiny must be evidence in the process via the SAR panel meetings and minutes The SAR Panel will call on the author throughout the SAR process to address any areas of concerns they may have.

The SAR ToR will consider how and when to commissioning learning resources from the learning from this SAR.

2.5. Step 5, Final Report and Recommendations

The SAR Panel will consider and when appropriate endorse the final report and draft an action plan to address the recommendations within the report.

If there has been involvement from the individual or an advocate, the author will offer the opportunity to 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.

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

The final findings report, and recommendations will be presented to the SAB for consideration and endorsement 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 SAR Panel Chair or SAB Business Manager.

2.6. Step 6, Action Plans

Once the SAR report and action plan are endorsed by the SAB. The SAB Business Manager will:

- Add the recommendations and agreed actions to the SAR Multi-Agency Action Plan
- Agree publication plan for the SAR.

The recommendations plan will be monitored by the SAB Business Manager and or the SAB Subgroups and areas of risk reported to the SAB via the Subgroup Chairs and/or SAB Business Manager

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 SAR Multi-Agency Action Plan, which is kept up to date by the SAB Business Manager.

A summary report on progress on the learning SAR Multi-Agency Action Plan will be presented to each SAB.

Scheduled a 2 yearly of the action plan by the SAR Panel

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 SAR Panel which will be shared with partner agencies for dissemination and use in training.

The SAB's Quality Assurance Framework references learning 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, a copy will be shared with the national SAR library.

3. SECTION 3, Important considerations for SAR'S

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 SAR that they may be required to attend a Coroner's inquest.

3.2. Support for the Person

All processes should engage the person and take account of their wishes. It is important that the person is informed that the purpose of this review is to understand how different agencies worked together 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 person has capacity or can be appropriately supported, they will be invited to contribute to the SAR. It is important to support them to contribute their views if they wish. They should be informed of the SAR and any findings shared with them. This is an inclusive process and support, including access to advocacy, 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 person, members of their family and social network will be informed about the SAR considering how the communication may impact on them.

The person 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 SAR and sharing the findings.

If the report needs to be shared with the person, relevant members of their family and social network 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 person, relevant members of their family and social network at any point during the process. This should be clearly communicated at the start of the process.

A leaflet can be found in Appendix 5, which should be provided when the person, relevant members of their family and social network is informed that a SAR is to take place.

3.3. Support for the relevant members of the persons family and social network

If the person has capacity and gives consent for their family and social networks who have significant involvement in their lives to be involved with the review; or the person has passed away, then relevant members of their family and social networks will be invited to contribute. It is important that they are 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 relevant members of their family and social networks to contribute their views if they wish.

The SAR Panel when setting the Terms of Reference will consider how relevant family members and social networks will be informed about the SAR taking into account how the communication may impact on them. The SAR Panel will consider the family and social network dynamics when setting the terms of reference ensuring that all relevant family and social networks 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 contributors 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 relevant family and/or social networks 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 and/or social networks/ at any

point during the process. This should be clearly communicated at the start of the process.

A leaflet can be found in Appendix 5.

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 a person 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.

Staff should be asked their views about what, in their opinion, could have made a difference for the person or their relevant family and social networks.

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.

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 SAB Business Manager in accordance with the author Data protection arrangements. The SAB Business Manager will keep all record for the review as determined by data retention policies.

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 will 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 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.

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.
Safeguarding reviews - SCIE

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 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.

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 (SARiRT)

Is a methodology and series of tools that aim to allow learning to be turned around swiftly, with limited demand on participants' time.

The model supports the identification of practical learning by enabling a focus on barriers and enablers to timely, effective, personalised safeguarding.

The approach seeks to identify social and organisational factors that make it harder or easier to safeguard adults well. Standardised processes, analytic tools and templates support a 'systems approach' to the analysis and efficiency of process.

Key features include:

- Strategic commissioning
- Project planned process
- The final output is a system findings report
- Providing the person or family the opportunity to contribute to the process

Refer to the SCIE website when considering the SAR in Rapid Time Approach: Safeguarding Adult Reviews (SARs) In Rapid Time - SCIE

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	SAR Quality Markers Handbook - SCIE	Safeguarding Adults Review (SAR) Quality Markers handbook - SCIE	SCIE Quality Markers to be adhered to during the process.
2	Appendix 2 - Notification of a Case for Consideration July 2024 V.1.0	https://sabberkshirewest.co.uk/wp-content/uploads/2024/08/Appendix-2-Notification-of-a-Case-for-Consideration-August-2024-V.1.1.docx	SAR Notification form
3	Appendix 3 - SAR Tracking Tool	Appendix-3-SAR-Tracking-Tool-V.2.0-July-2024.pdf (sabberkshirewest.co.uk)	SAR panel track progress and decisions made throughout the SAR
4	Appendix 4 - SAR Panel TOR June 2024 V.1.0	https://sabberkshirewest.co.uk/wp-content/uploads/2024/07/SAR-Panel-TOR-June-2024-V.1.0.pdf	SAR Panel Terms of Reference
5	Appendix 5 – SAR Information Leaflet	https://sabberkshirewest.co.uk/wp-content/uploads/2024/07/Appendix-5-SAR-Information-Leaflet-V.1.0.pdf	To be given to the person, members of their family and social network when being informed that a SAR is to be undertaken.