Gloucestershire Safeguarding Adults Board

Safeguarding Adults Review (SAR) Protocol

Originally Produced: November 2016

Updated: March 2025

Contents

The purpose of this protocol is:

- To ensure that local practice is in line with the Care Act 2014 statutory requirements for the Safeguarding Adults Board to undertake Safeguarding Adults Reviews, both statutory mandatory and non-mandatory, and learning events.

- To provide a framework that enables Safeguarding Adults Reviews to be undertaken in a proportionate way.

- To recognise the Safeguarding Adult Review Quality Markers 2022 and the findings of the National Safeguarding Adult Review Analysis (First and Second National Analysis of Safeguarding Adult Reviews).

- To recognise that there are other forms of statutory reviews (such as Domestic Abuse Related Death Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews, Multi Agency Public Protection Arrangement Reviews, Child Safeguarding Practice Reviews and Learning from Lives and Deaths Reviews for individuals with a Learning Disability) and the importance of managing the interface between them.

- To recognise that the adult and/or their family must always be offered the opportunity to contribute to the review process and are provided with the necessary support to do so. This may include involving a Care Act advocate.

1. Introduction

1.1. The Care Act 2014 introduced a number of new duties with regard to Safeguarding Adults. One of these duties is that the Safeguarding Adults Board must undertake 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 reasonable cause for concern about the way agencies worked together to safeguard the individual (s44). The Safeguarding Adults Board must also undertake a SAR if an adult has not died but the Board knows or suspects that the adult has suffered serious abuse or neglect.

1.2. The Safeguarding Adults Board can also undertake reviews in other situations, if it feels that doing so would strengthen multi-agency working.

1.3. Members of the Safeguarding Adults Board are required to co-operate and contribute to the carrying out of a review by sharing information and applying the lessons learnt. The Care Act (s45) also enables the Safeguarding Adults Board to request relevant information from anyone in order to support it in undertaking a review.

1.4. Every review should take into account what was known to practitioners working with the individual or could have reasonably been expected to be known by them at the time. Consideration should also be given to the capacity of the person at risk and their views and choices.

1.5. SARs are not enquiries into how an adult at risk died or who is culpable. They are an opportunity to consider how agencies worked together, to share lessons learnt so that we can further improve the way we work together with adults at risk of abuse or neglect.

1.6. This protocol reflects the six key safeguarding principles that underpin all adult safeguarding work:

Empowerment	People being supported and encouraged to make their own decisions and informed consent
Prevention	It is better to take action before harm occurs
Proportionality	The least intrusive response appropriate to the risk presented
Protection	Support and representation for those in greatest need
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability	Accountability and transparency in delivering safeguarding

1.7. The Safeguarding Adult Review Quality Markers Comprehensive Checklist Tool dated March 2022 (a copy of which can be found at Appendix 8), should be referred to at every stage of undertaking a SAR from the initial referral to the production of the improvement plan and the evaluation of its impact.

2. When should a Safeguarding Adults Review be undertaken?

2.1. A SAR can only be commissioned by the Safeguarding Adults Board.

2.2. There is a statutory and mandatory duty on the Board to arrange a review of an adult (aged 18 plus) in its area with needs for care and support (it is not relevant to this duty for these needs to have been met by the provision of care and support funded by the individual or other public bodies) if:

a. There is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other organisations worked together to safeguard the person. **And**

b. The person has died and the Safeguarding Adults Board 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**

c. The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect. In these situations serious abuse or neglect would be indicated if:

- The individual would have been likely to have died had there not been some form of intervention or they have suffered permanent harm
- The person has experienced reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

2.3. SARs undertaken under these criteria are described as statutory mandatory reviews in this guidance.

2.4. The Act also gives a Safeguarding Adults Board the opportunity to arrange a review in other situations involving an adult in its area with needs for care and support if it is felt there would be learning to be obtained. The Gloucestershire Safeguarding Adults

Board will consider requests to undertake a statutory but non-mandatory review in situations where:

a) An adult has received support through the Safeguarding Adults process due to concerns of abuse or neglect **And**
b) Whilst there are no concerns about the way that individuals within agencies have worked together, there is evidence that the policies and procedures of one or a number of the agencies involved did not support this joint working. This may include issues around the sharing of information or the use of resources. **Or**
c) There are examples of good practice that could be used to identify lessons that could be applied by agencies when working with adults at risk in the future.

3. What is the purpose of a Safeguarding Adults Review?

3.1. The statutory Guidance for the Care Act describes the purpose of a SAR as being "to promote effective learning and improvement action to prevent future deaths or serious harm occurring again". The aim of every review should, therefore, be to learn lessons from the case and to make sure that those lessons are applied to future cases by all agencies in Gloucestershire to prevent similar harm occurring.

3.2 It is not the role of a SAR to hold any individual or organisation to account. There are other processes that exist for this purpose which include criminal proceedings, disciplinary processes, employment legislation and regulatory systems for both services and professionals.

4. Requesting a Safeguarding Adults Review

4.1. A request for a review can be made by:

- Any organisation/agency working with adults in Gloucestershire
- Any professional from the Board's partner agencies
- The individual concerned, a family member or another interested partner such as the Coroner or Member of Parliament

4.2. The following considerations should be made when deciding whether to request a statutory and mandatory review:

- The concern relates to an adult with needs for care or support – whether or not they are/were in receipt of services

- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused

- There are concerns about failings relating to two or more organisations working with the individual and the potential to identify and improve multi-agency practice and partnership working.

4.3. The Referring Agency must ensure that a discussion has taken place with their safeguarding lead, who will advise them. The agency may want to consider discussing the matter with the other agencies and either submitting a joint referral, or it may be

prudent to initially conduct an Information Gathering Meeting involving those agencies, in order to obtain a clear picture. Any agency may call an Information Gathering Meeting and advice can be obtained from the Safeguarding Adults Team, if required.

4.4. There will be situations where an incident has triggered an internal or organisational process (e.g. RCA, SI). This organisational investigation should take place without delay, but as part of their internal mandatory investigation or review process the organisation should consider:

- Has the investigation highlighted concerns about another organisation or how people worked together?
- Has information come to light during the investigation that identifies abuse or neglect that was not previously recognised?

4.5. Some requests may relate to people who are also subject to other statutory review processes such as a Domestic Abuse Related Death Reviews, Mental Health Homicide Review, MAPPA Review, Learning from the Lives and Deaths of individuals with a Learning Disability Review (LeDeR) or a Child Safeguarding Practice Review. See Appendix 7 for further information on these statutory review processes. In these circumstances, the request should highlight the links to the other reviews. The Board Business Manager will then discuss the request with the Chair of the Safeguarding Adults Board and the Chairs of any of the other reviews to agree how the interface should be managed.

4.6 SARs do not form part of any disciplinary process. However, if there are disciplinary matters in progress regarding the situation being requested for consideration, this information should be noted on the referral form.

4.7. To make a request for a SAR the referral form - Notification for Consideration for a SAR (Appendix 1) should be completed and sent for the attention of the Board Business Manager at the following email address: carolyn.bell@gloucestershire.gov.uk

5. Who makes the decision to undertake a Safeguarding Adults Review?

5.1. When a request has been received, the Chair of the Safeguarding Adults Review sub group will inform/present the referral to members of the SAR sub group at the next planned meeting (or arrange an extraordinary meeting if required).

5.2. To assist with the decision making, organisations identified in the request as having worked with the individual may be approached to complete an initial overview form and brief chronology (Appendix 2).

5.3. The sub group will consider the information provided and make a recommendation to the Chair of the Safeguarding Adults Board as to whether the request meets the requirements for a statutory and mandatory review.

5.4. The sub group will also consider requests for statutory non-mandatory reviews using the criteria outlined in **paragraph 2.4** to make this decision. If the sub group feels the request meets the criteria for a statutory non-mandatory review, they will make a recommendation to the Chair of the Safeguarding Adults Board that a review is undertaken.

5.5. The final decision as to whether to proceed to a review will be made by the Chair of the Safeguarding Adults Board.

5.6. The Safeguarding Adults Board Business Manager, on behalf of the Independent Chair of the Safeguarding Adults Board, will inform the following people, in writing, of the decision to undertake a SAR.

- The person/organisation that requested the SAR
- Members of the Safeguarding Adults Board
- Members of the SAR sub group
- Councillors who represent the division of where the adult resided
- The GCC Communications team

6. The SAR Sub Group's responsibilities for Safeguarding Adults Reviews

6.1. When a SAR has been agreed the Sub Group will consider:

- An independent facilitator/author will be identified, who will assist in establishing the terms of reference for undertaking the SAR
- Identify the agencies that should be involved in the SAR
- Agree who will be responsible for communicating with the adult and/or their family or advocate.
- Consider if it would be appropriate to communicate with the person who is alleged to have caused the abuse or neglect.
- Agree a timescale for completion of the SAR
- Identify which methodology should be used to facilitate learning from this SAR.

6.2. The Board has agreed that, for mandatory reviews, an external person may be appointed or it may be appropriate to use a board partner, if they:

- Have the skills required to undertake the review
- Are independent, and work for an organisation or agency that is not involved in the review

6.3. For non-mandatory reviews an external person may be appointed or it may be appropriate to use an individual working for an organisation in Gloucestershire, if they:

- Have the skills required to undertake the review
- Work for an organisation or agency that is not involved in the review.

6.4. The sub group will receive regular updates on the progress of the review as agreed in the terms of reference.

6.5. The Chair of the SAR sub group will ensure that progress updates are provided to the Safeguarding Adults Board at its scheduled meetings.

6.6. The draft final report together with a draft action plan will be presented to both the sub group and the Chair of the Safeguarding Adults Board.

6.7. The Chair of the SAR sub group, together with the Board Business Manager, will ensure that the final report is presented to the Board as soon as possible after its completion.

6.8. The Chair of the SAR sub group will also agree with the Review Chair how the draft

report is to be shared with the individual and/or their friends or relatives. This will also include information on publication.

6.9. The final report will be published on the GSAB website and sent out as a GSAB Alert. It will also be shared with the GSAB Workforce Development sub group.

6.10. The sub group will be responsible for identifying who will take responsibility for obtaining assurance on each aspect of the plan. This assurance will include confirmation that the required steps have been taken and the lessons learnt have been shared across organisations in Gloucestershire. These actions will be monitored by the SAR sub group.

6.11. The Chair of the SAR sub group will provide updates to the Board on the progress of the action plan and will request of the GSAB that a review is closed once all the actions have been completed.

7. Role of Person leading the Safeguarding Adults Review

7.1. The person leading the SAR will be accountable to the SAR sub group during the period of the review.

7.2. It is expected that a person leading/chairing a review will have the appropriate skills and experience to lead a review, as outlined in the Care Act guidance. These include:

- Strong leadership skills 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
- Safeguarding knowledge
- Inclination to promote an open, reflective learning culture
- Independence from the case under review and of the organisations involved.

7.3. During the review the person leading the review will be responsible for:

- Achieving consensus of opinion about the key areas of learning and/or areas of change identified
- Ensuring that agency representatives work together positively
- Ensuring that an appropriate level of challenge is provided throughout the process
- Identifying good practice as well as areas of development and including both in the report
- Agreeing with agencies and the Chair of the SAR sub group who will be the named individual responsible for contact with the individual or family members and how the individual or their families/friends will contribute to the review
- Keeping the SAR sub group Chair updated on the progress of the review.

7.4. The person leading the review is also responsible for writing the review report ensuring that it:

- Is in plain English
- Clearly identifies the learning points and recommendations being as "SMART" (Specific, Measurable, Achievable, Relevant and Time-bound) as possible.
- Is suitable for publication without needing to be amended or redacted.

7.5. Once the report is written, the person leading the review is responsible for seeking agreement from all contributing agencies that they are satisfied that the report reflects the information shared and discussions held as part of the review. If it is not possible to obtain agreement, the person leading the review has the final decision on what is written. The Chair of the Safeguarding Adults Board should, however, be notified that agreement has not been obtained from all agencies.

7.6. The person leading the review is also responsible for:

- Agreeing with the SAR sub group Chair and the Chair of the Safeguarding Adults Board how the report will be shared with the Board members, as well as the individual/the family.
- Participating in any agreed communication arrangements regarding the report, including publication.

8. Safeguarding Adults Reviews – Methodologies

8.1. There are many ways that learning can be obtained, but a review must be proportionate in the approach it takes. The methodology to be used for a review will be discussed by the SAR sub group and a provisional recommendation about the most appropriate learning method for the case under consideration will be identified before the review begins.

8.2. A summary of the approaches that may be used are contained in Appendix 3. It is recognised that the list provided in the appendix is not exhaustive and the SAR sub group may wish to use its collective expertise to recommend an alternative approach.

9. Undertaking a Safeguarding Adults Review

9.1. The person leading the SAR will be supported in this task by the Board Business Manager and administrative support.

9.2. The methodology used for a review will affect the level of multi-agency meetings required to complete a Review.

9.3. Each involved agency will provide information as required by the methodology being used for the review.

9.4. The person leading the SAR will agree with all agencies involved how records will be presented during the review process. This may require reports that are anonymised through redaction, and an agreement made on the abbreviations to be used by all agencies. It may be that consent is obtained from the individual that their information can be shared in an un-redacted form during the review process.

9.5. Agencies must be aware that there could be public scrutiny of information provided to

the Review. All agencies should therefore ensure that their submissions are approved by their organisation before they are shared with the review. This may, if considered appropriate, include obtaining legal advice prior to submission.

9.6. The report produced at the conclusion of the SAR will be anonymised with regard to individuals – including the individual/or their families and professionals. Agency names and job roles will also be anonymised.

9.7. The final draft report will include draft recommendations which should be reflected in the Action Plan provided together with the report.

10. Timescales for a Safeguarding Adults Review

10.1. A review must be undertaken in a timely manner. The process should be completed within six months of the decision being made by the Chair of the Safeguarding Adults Board that a review is to be undertaken.

10.2. It is recognised that there may be occasions when the issues being considered by the review may mean that a longer timescale is needed. In these situations the person leading the review must agree the revised timescale with the Chair of the Safeguarding Adults Board.

10.3. If during a review, issues regarding criminal actions or issues regarding the safety of a service are identified, this should be immediately shared with the appropriate authority. The person leading the review must inform the Chair of the SAR sub group and the Chair of the Board and agree any changes required to the timescale or the scope of the review.

11. Sharing information during a review

11.1. The Care Act contains two duties that will need to be considered by all agencies asked to participate in a review.

11.2. Organisations represented on the Safeguarding Adults Board in Gloucestershire are required under the Care Act (s44.5) to co-operate in and contribute to the carrying out of a SAR with a view to:

- Identifying the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases.

11.3. Section 45 of the Care Act places a legal duty on any organisation or individual asked to provide relevant information to the Board to share what they know with the Board or the person identified by the Board (i.e. the person leading the review). This section applies if the information being requested by the Board is to enable or assist it to perform its functions. As a SAR is a function of the Board, this section will apply to requests for relevant information made as part of a SAR.

12. Use of an independent advocate

12.1. An independent advocate must be provided to support and represent an adult (where the adult is still alive), who is subject to a safeguarding review if:

- It is considered the person would experience substantial difficulty in participating in the review person **and**
- They do not have an appropriate person (friend or family) that could support their involvement in the review.

12.2. If the person already has a Care Act Advocate or an IMCA, unless inappropriate, this advocate should be used.

13. Involvement of Families

13.1. Families should be informed if a review is going to take place. They should be offered the opportunity of contributing to the review process, but how that is done will depend on the methodology used and the views of the family.

13.2. It is the role of the person leading the review to ensure that an individual is identified to be the contact with the family or person. The person leading the review will also agree the manner in which family members or friends will contribute to the review if they wish to do so.

13.3. The consent of the family or individual is not however required for a review to take place.

14. Responsibility to staff

14.1. Staff directly involved in working with an individual subject to a SAR should be notified by their employing agency that the decision has been made to undertake the review.

14.2. Information about the review process and how the staff members may be involved in the review should be fully explained by their employing organisation. (Appendix 8)

14.3. Support to staff members should be provided by the agency/organisation in line with their HR requirements.

14.4. Agencies may also need to consider what support is required if a systems approach is used to undertake the review, as this approach requires a high level of reflection and interaction from individuals. Whilst the outcomes of this approach should be very positive, individuals can experience it as being challenging.

15. Final Report and Action Plan

15.1 All SAR reports are owned by the Safeguarding Adults Board. The report and action plan are only final when accepted by the Board.

15.2 Before publication the Board will need to consider what impact the publication may have on the adult (deceased or living), family members or others affected by the review.

15.3 The Board will ensure that the report complies with the General Data Protection Regulations (GDPR) 2016 and the Data Protection Act 2018, before it is shared.

15.4 All action plans will explicitly set out how agencies will evidence that an action has been completed and how the learning from the SAR will be embedded into practice.

15.5 The Safeguarding Adults Board will be provided with updates on the action plan and a review will only be closed when the Board is satisfied that all the actions have been completed.

15.6 A report from every review undertaken by the Board, will be published on the Board website, if it is appropriate to do so.

15.7 At the point of publication the Safeguarding Adults Board Chair will co-ordinate the writing of a reactive/proactive statement with Gloucestershire County Council's Communications team.

16. Resolving disagreements between Safeguarding Adults Boards (SABs)

It is acknowledged that there will be cases where adults have moved from their 'home' area and may be placed and funded by an organisation that is in another area. If that is the case, a SAR should be carried out by the Safeguarding Adults Board responsible for the location where the serious incident took place.
Boards and organisations should cooperate across borders, and requests for the provision of information should be responded to as a priority.

If agreement cannot be reached on the requirement for a SAR to be undertaken, this will be resolved in the first instance by the relevant Board Managers, with ultimate decision making and discussion being resolved by the Independent Chairs of the Boards. Independent Chairs will agree on the mechanisms for presenting SARs that have cross border learning.

Appendix 1 – SAR Referral Form

SAR Referral Form

Gloucestershire Safeguarding Adults Board (GSAB)

Referral for a Safeguarding Adults Review

Care Act 2014 – Section 44 Safeguarding Adults Reviews

The GSAB must arrange 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) in cases where:

- An adult with care and support needs has died as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult *or*
- An adult is still alive but has experienced serious abuse or neglect.

Care Act 2014 – Non s44 Reviews

The Act also gives a Safeguarding Adults Board the opportunity to arrange a review in other situations involving an adult in its area with needs for care and support if it is felt there would be learning to be obtained. The Gloucestershire Safeguarding Adults Board will consider requests to undertake a non-mandatory review in situation where:

a) An adult has received support through the Safeguarding Adult's process due to concerns of abuse or neglect

And

b) Whilst there are no concerns about the way that individuals within agencies have worked together, there is evidence that the policies and procedures of one or a number of the agencies involved did not support this joint working. This may include issues around the sharing of information or the use of resources.

Or

c) There are examples of good practice that could be used to identify lessons that could be applied by agencies when working with adults at risk in the future.

The GSAB Safeguarding Adults Review Sub-group needs as much information as possible to make a proportionate decision as to how to respond to a case referral, to ensure that maximum learning is achieved for the GSAB and its partners. Therefore please provide as much information on this form as possible. If you have any questions, please do not hesitate to contact the GSAB Business Manager (carolyn.bell@gloucestershire.gov.uk)

1. ***Referrer***

Name:	
Job Title:	
Agency:	
Telephone number:	
Email Address:	
Date of Referral:	

2. ***The Adult***

Name:	

Date of Birth:	
Date of Death (where applicable):	
Address:	
Agencies Involved (where known):	

3. Referral reasons for a Safeguarding Adults Review:

What care and support needs does the person have?	
What abuse or neglect did the individual experience?	
How did the adult come to this harm?	
How could agencies have worked together better to prevent this abuse or neglect?	
Has any other review of this case already taken place and what was the learning from that review?	

4. Background and any other relevant information

Please detail any other information you feel may be relevant to assist the Sub Group in making a decision about this case.	

Please return the completed form to: Carolyn.bell@gloucestershire.gov.uk

Appendix 2 - Request for Agency Case Information Form

Name of Agency:

Name of Person Completing the Form:

Date Information Required by:

The Care Act 2014 placed a statutory duty on the Local Safeguarding Adults Board to arrange a review of an adult (aged 18 plus) in its area with needs for care and support (it is not relevant to this duty for these needs to have been met by the provision of care and support funded by the individual or other public bodies) if –

a) There is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other organisations worked together to safeguard the person **and**
b) The person has died and the Safeguarding Adults Board 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**
c) The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect

The Safeguarding Adults Board can also arrange a review in other situations involving an adult in its area with needs for care and support if it is felt there would be learning to be obtained. The Gloucestershire Safeguarding Adults Board (GSAB) will consider requests to undertake a non-mandatory review in situations where:

a) An adult has received support through the safeguarding adults process due to concerns of abuse or neglect **and**
b) Whilst there are no concerns about the way that individuals within agencies have worked together, there is evidence that the policies and procedures of one or a number of the agencies involved did not support this joint working. This may include issues around the sharing of information or the use of resources **or**
c) There are examples of good practice that could be used to identify lessons that could be applied by agencies when working with adults at risk in the future.

Your agency has been identified as being involved in supporting an adult who has been referred to the GSAB to consider if it meets the requirement for a safeguarding adults review – either statutory mandatory or non-mandatory.

Please use this form to provide information on your agency's involvement with the named individual/s. This can be a brief outline – it is required to help the Board decide the next steps. The GSAB may request more information at a later stage if required.

Details of Adult/s at Risk

1. Surname		**2. Surname**	
First Name		**First Name**	
Date of Birth		**Date of Birth**	
GP		**GP**	
Address		**Address**	

Details of person/s alleged to be responsible for the abuse or neglect (if appropriate)

1. Name		
Date of Birth		
Address		
Relationship to adult		

2. Name		
Date of Birth		
Address		
Relationship to adult		

Completion of Chronology Table – significant dates and events between ……. and ….. (Chronology template attached)

Brief Overview of Case Record Relating to the Adult (include details of any records reviewed to complete this; family and/or other agency involvement)

Please return this form to carolyn.bell@gloucestershire.gov.uk
Marked for the attention of the GSAB Business Manager

Appendix 3 - Methodologies for Reviews

There are many ways to achieve learning and a proportionate response needs to be given to each review. When the SAR sub group is considering which methodology would be most appropriate for a review, they may want to consider the approaches detailed below. It is recognised that this list is not exhaustive and the sub group will use the expertise available to it to recommend the most appropriate learning method for the review.

Significant Event Analysis

This approach brings together people from the agencies involved to consider significant events within the situation under review to analyse what went well and what could have been done differently.

The approach has been used for many years in the NHS to analyse a significant event in a systematic and detailed way to ascertain what can be learnt about the overall quality of care and to indicate changes that might lead to future improvements.

The organisations involved are asked to provide agency reports or chronologies that detail their involvement with the individual. This information is then used to support the discussion during the multi-agency learning event that forms the central aspect of this approach.

The person leading the review will be required to undertake a facilitation role, bringing people together and encouraging an open discussion on the support that was provided to an individual. This will require the reviewer to have the ability to handle multiple perspectives together with sensitivity to complex group dynamics.

The following people should take part in the learning event:

- Frontline practitioners, including those involved with the individual as appropriate
- Line Managers
- The authors of the agency reports/chronologies
- Professional Leads/experts (as required)

Ground rules should be agreed before the meeting starts to reinforce the educational spirit of the process, ensure opinions are respected and individuals are not ‘blamed’. Minutes of the meeting should be taken and action points noted.

The analysis and discussion during the review will be supported by having the following available:

- Policies and procedures – both multi-agency procedures such as the GSAB policy and individual agency policy/procedures that are relevant to the review.

- Chronology or agency reports completed by each organisation. These should contain all key events and highlight key areas of learning or good practice from each agency.

This material should be circulated to all attendees before the learning event.

The event should consider:

- What happened
- Why did it happen in this way
- Is it consistent with the agency policies/ procedures
- What are the areas of good practice
- Areas for improvement
- Lessons learnt
- What has already been changed or actioned as a result of this situation

After the learning event the person leading the review will need to consolidate all the information provided into an overview report that contains an analysis of key issues, lessons learned and recommendations.

A further meeting with all involved in the learning event should be held to consider the draft report and make any changes required to agree the report.

Family members can be involved in this process by considering the initial outcomes from the learning event, identifying any areas that require clarification and offer their perspective on areas for improvement and areas of good practice.

To obtain further guidance on Significant Event Audits go to www.npsa.nhs.nrls/gp

Individual Management Reviews

Individual Management Reviews (IMRs) are a way of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. Each organisation's IMR should identify good practice alongside the identification of areas where systems, processes, or individual/ organisational practice could be improved.

Individual Management Reviews can be used for a desk-based review or a review that involves a multi agency panel. The IMRs will be provided by each organisation for consideration by the review group. The role of the review group is to ensure areas of uncertainty or conflicting accounts in agency recording is explored, areas of good practice identified and issues identified that could enhance multi agency working in the future. The person leading the review would be responsible for writing an overview report based on the individual IMRs and the panel discussions.

Individual Management Reviews can also be used as one of the sources of information for a traditional Serious Case Review.

The involvement of family members or families in an Individual Management Review can be challenging. The person leading the review may wish to consider how the family can contribute to the work undertaken by the review group. This should

Include discussions with each organisation about the appropriateness of sharing a summary or the whole content of each organisation's review. A template for an Individual Management Review (IMR) is available below.

Individual Management Review

A checklist for completing an IMR is available in Appendix 4

Multi-Agency Combined Chronology

A chronology of events is a useful way of achieving an overview of a case from information obtained from a number of organisations (Appendix 6 - Chronology template). This enables a review to identify gaps in service provision or practice, missed opportunities for communication and areas of good practice. This methodology is best used when there is a focused period of multi agency involvement. It is not well suited to a review that is considering multi agency involvement over a number of years.

Once a combined chronology has been developed from each organisation's submissions, a workshop should be held. The workshop will be facilitated by the person leading the review. Lead practitioners and managers from each agency should be invited to the workshop and the combined chronology used as the basis for a reflection on the ways agencies worked together. This will lead to the identification of:

- gaps in service provision
- areas where practice could be strengthened
- organisational practice or procedures that impacted on the work undertaken
- missed communication opportunities
- examples of good practice
- recommendations for lessons learnt

An overview report based on these key areas will then be drafted by the reviewer and shared for agreement before submission to the SAR sub group.

Family members or the individual concerned can contribute to this approach by providing their own chronology based on their understanding of support provided by organisations.

Serious Case Review Model

This is the traditional approach to undertaking a review in both adults and children's services. Agencies involved are asked to submit both a chronology and an Individual Management Review. These provide the reviewer with a detailed analysis of each agency's work with the individual and an overview of the level of multi-agency involvement.

A Review Panel is established with the reviewer chairing this panel. The panel members are usually senior managers from the involved organisations and the person leading the review. The person leading the review may also wish to have a

representative from an advocacy or service user organisation to ensure that there is a level of challenge to the perceptions of professionals throughout the process.

The task of the review panel is to:

- clarify through challenge the information provided in the individual reviews
- obtain an agreed overview of the multi-agency involvement with the individual
- identify areas where there were gaps in service provision
- highlight missed opportunities to communicate
- consider areas of organisational/individual practice that impacted on the support provided
- comment on good practice

The person leading the review is responsible for writing an overview report. This should be considered by the panel in draft form, with agencies confirming that they are in agreement with both the report and the recommended action plan.

Family members or the individual could be involved in this form of review through regular discussions with a nominated person regarding the areas being considered by the review panel. Consideration should be given to sharing the finding of the review panel verbally before the report is written so that family members or the individual can offer their perspective on the findings.

SCIE – Systems Review (also known as Learning Together)

This approach has been used in child protection in the last few years but has only been used to date in a small number of adult safeguarding reviews.

The central idea of this approach is that any worker's performance is a result of both their own skill and knowledge and the organisational setting in which they are working. It looks at the quality of work produced by the combination of the worker and the tools available to them. This would include procedures, working conditions, resources and skills, as well as issues such as team and organisational cultures.

This requires the review to:

- reconstruct how professionals saw the case at the time: speaking to staff to get their perspective on the case as it unfolded, and why they chose the actions they took
- identify and analyse key practice episodes, and the contributory factors behind them, looking at significant periods and aspects of the case, the practice that occurred and the factors that influenced the work the professionals did
- interpret the broader significance, analysing the ways in which what happened reflects wider issues in the system

The review draws on two sources of data. The formal documentation of the different agencies involved and in-depth one-to-one conversations with key people involved in the case. The conversations are undertaken with staff, service users and families, and joint meetings of all the key professionals involved. Formal documentation will include records maintained by the

practitioners, as well as the policies and procedures of the involved organisations.

This approach does require both the person leading the review and those involved in the review team to have some knowledge about both the methodology and how ethnographic or open enquiry research is undertaken. Unlike all the other approaches in this appendix, this approach does not propose setting Terms of Reference for the review but rather identifying issues through the enquiry process.

The final report will contain both a narrative of multi agency perspectives and an identification of key practice episodes and their contributory factors. The report will make recommendations for strengthening future practice.

More information on this model can be found on the Social Care Institute for Excellence website www.scie.org.uk

Root Cause Analysis

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of adverse incidents. If the contributory factors and causal factors - the root causes - of an incident or outcome are understood, corrective measures can be put in place. 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. This approach can help to prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. 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.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes.
- To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence.
- There is usually more than one potential root cause of a problem.
- To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause(s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS.
- Focus is on the root cause and not on apportioning blame or fault.
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools;
- Resource intensive

More information on this model can be found on the NHS website:

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

Rapid Reviews

A Rapid Review is a methodology designed to streamline the learning process in Safeguarding Adults Reviews (SARs). It is designed to quickly generate learning by focusing on 'systems findings' that highlight social and organisational factors affecting day-to-day safeguarding practices. It is a valuable tool for improving the efficiency and effectiveness of safeguarding practices.

The Rapid Review approach aims to:

- Speed up learning: It provides quicker insights with minimal time demands on participants.
- Identify practical learning: By focusing on barriers and enablers to effective safeguarding.
- Analyse social and organisational factors: It looks at what makes safeguarding more effective
- Systems findings: Identifies factors that impact practitioners' effectiveness within and between agencies.
- Remote facilitation: Utilises remote meeting tools, eliminating the need for face-to-face contact.
- Concise reporting: The final report is succinct and practical, excluding detailed methodology and processes.

The GSAB Rapid Review Process can be found in the document below.

GSAB SAR Rapid Review Process April

Appendix 4 - Guidance for completion of an Individual Management Review Report Form.

1. Anonymity

Throughout the report please ensure that your report is fully anonymised including names, addresses, professional names and identifiable locations e.g. names of day centres, care homes with nursing, hospitals, health centres etc. Please provide an identifying key as a separate document.

2. Introduction

This should include a:

- Brief description of your organisation and its role in relation to key individuals.
- The agreed Terms of Reference (ToR) for the review – copied from the ToR provided by the SAR sub group.
- The sources of information that have been used to inform the review e.g. file reports, supervision records, training documents, policies and procedures, management information and interviews with staff (stating job title only not names). If you have not been able to interview staff please state the reason for this.
- Detail of related reviews and processes. If any parallel reviews (i.e. untoward incidents, mental health review, disciplinary investigations [with no identifiable details] are ongoing or completed but relevant, please make a note in this section

3. Family and household composition

Please include a description of the Adult at Risk, Person(s) Alleged Responsible and other relevant family members and significant others that your agency has had contact with.

4. Chronology of Service Provision and Involvement

This section should contain a summary of the events that occurred, information known to the agency, any assessments undertaken and decisions reached; the services offered and provided and any other action taken.

Episodes of service provision may be broken down as appropriate e.g. by periods of the case being ‘open’ with your agency, by change of keyworker and so on.

5. Analysis of involvement

The analysis should consider the events that occurred, the decisions made and the actions taken or not taken. Consideration should be given to not only what happened but why. Practice should be assessed against policies, guidance and legislation.

The following are examples of the areas that should be considered for all reviews:

Service and practitioner standards:

- Was the agency's involvement in line with organisational expectations of services and/or national expectations of this service?
- Were practitioners sensitive to the needs of the adult(s) or the persons alleged to be responsible?
- Were they knowledgeable about potential risks of abuse or neglect?
- Were they aware of what to do if they had concerns?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Was the level of staff supervision appropriate and did it address the issues for this case?
- Were senior managers involved at the appropriate points?

Please highlight good practice as well as that which in hindsight could have been improved

Policies, procedures and risk assessment:

- Did the agency have policies and procedures in place for dealing with safeguarding concerns?
- Were these procedures and policies effective, and agreed by practitioners to be effective and worth using?
- Did the agency have policies and procedures for risk assessment and risk management?
- Were these assessments correctly used in this case?
- What assessments were undertaken by the agency?
- Were any opportunities to undertake assessments missed?
- Do assessments and decisions appear to have been reached in an informed professional way?
- Was any threshold applied for accessing the service appropriate and in line with agency thresholds?
- Did actions or risk management plans accord with assessments and decisions made? Were appropriate services then offered or provided?
- Were appropriate statutory actions taken in line with the relevant time frames (reviews, re-assessments, visits)?

Person centred focus:

- When and in what way were the person's wishes and feelings ascertained and considered?
- Were they given enough information, options and time to make informed decisions?
- If the individual was not able to describe their views and wishes, what steps were taken to obtain them?
- Was practice in accordance with the Mental Capacity Act?
- Was the individual signposted or referred to other agencies that they might prefer to work with?

- Was the practice sensitive to the age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status of the people concerned?
- Was any disability or vulnerability considered and responded to appropriately?
- Were services accessible for this person?

Inter-agency working:

- Did the agency comply with working protocols agreed with other agencies, including any information sharing protocols?
- What evidence was there of good inter-agency activity?
- Did anything adversely affect the inter-agency activity?

Good practice:

- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Was any additional support or service provided above what would normally be offered?
- Were there any examples of good practice over and above that which would be routinely provided?

Lessons to be learned:

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard adults at risk of abuse or neglect?
- Where can practice be improved?
- Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- If you have highlighted areas of work that were not of the required standard, please consider what contributed to services being below expectations
- Individual worker's situations, the organisational structure culture or the political context?
- Did anything or anyone appear to interrupt the decision making process?
- Did anything adversely affect inter-agency activity?
- Have any previous reviews made recommendations about similar concerns and why weren't the lessons embedded from these previous reviews?

Terms of reference

In addition to the questions above, address any specific issues in the terms of reference.

6. Conclusions

Pull together the findings and analysis in order to comment on:

- Service provided, quality of practice and adherence to procedures
- Appropriateness of policies, procedures, guidance, training and supervision
- Decision making
- Action taken in respect of decisions made
- Resource implications, where this is directly relevant

7. Recommendations

Individual agency recommendations for action contained in the report will be considered as part of the review. The review may, however, also recommend further actions for your agency which will be included in the final overview report.

Any individual agency recommendations not included in the final SAR Report are expected to be acted on within individual agency governance arrangements. Recommendations for action must flow from your conclusions. Recommendations can include changes for your agency procedure, practice, or deployment of resources. In addition you may make recommendations that may have an impact on other agencies as well as your own.

Any recommendation that suggests immediate action is required should be reported to your senior manager and the person leading the review. They should not wait until the completion of this report.

8. Learning the Lessons

Please identify how your agency intends to:

- Feedback the conclusions of the IMR to staff
- Communicate and disseminate lessons learned from the Safeguarding Adults Review.

Appendix 5 - Agency Chronology of Adult's involvement with Service Provider/Agency

Name of Service Provider/agency:

Name of Adult:

Name/role of person Completing Chronology:

Date:

This Chronology is the record of your agency's involvement with the adult and their family (and any significant other people). It is an account of what happened – how the adult came to your attention, what assessments were undertaken, what services were offered, significant events and crisis that occurred and what happened as a consequence. Accurate and complete individual agency chronologies are essential elements of an effective review as they are collected together in the form of a 'combined chronology. This document provides important insights into how key issues were identified and managed, inter and intra-agency communication, risk recognition, service provision etc.

Timeline for events

Date/time – suggest one line per date, use greyed line for different years etc.	**Source of Information –** e.g. reflection, LAS, professional records, Tel call, email	**Name of professional involved and role**	**Event –** detail involvement with the adult, using direct quotes if relevant to prevent misinterpretation.	**Comments –** relate event to compliance with organisations policies/procedures, any areas where there are possibilities to improve practice, any more information required/ questions to be answered through the review

Appendix 6- Parallel Review Process

1. Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

2. Domestic Abuse Related Death Review (DARDR)

A Domestic Abuse Related Death Review (DARDR) will be undertaken when there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person who is 'personally connected' such as: intimate partners, ex-partners, family members or individuals who share parental responsibility for a child. There is no requirement for the victim and perpetrator to live in the same household.

The DARDR process also covers suicide cases to be considered for review in circumstances where there is a significant history of domestic abuse and where it is clear lessons are to be learnt to improve agency response to domestic abuse.

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet

3. MAPPA Serious Case Reviews

According to the MAPPA (Multi Agency Public protection Arrangements) Guidance published in 2012 (updated 2024), a Serious Case Review (SCR) will be commissioned

by the MAPPA Strategic Management Board when the following mandatory criteria have been met:

- The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.

- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

Discretionary MAPPA SCRs may also be undertaken when a further serious offence is committed, where there has been a significant breach of the MAPPA guidance or where it is in the public interest to do so.

20 MAPPA Serious Case Reviews - Multi-Agency Public Protection Arrangements - MAPPA (justice.gov.uk)

4. Child Safeguarding Practice Reviews

Working Together 2023
Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding incidents which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

Serious child safeguarding cases are those in which:

• Abuse or neglect of a child is known or suspected and

• The child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (National Panel) if:

(a) The child dies or is seriously harmed in the local authority's area, or

(b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The local authority must notify any event that meets the above criteria to the (National)

Panel. They should do so within five working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days. (Serious Incident Notifications - SIN). Others who have functions relating to children (any person or organisation with statutory or official duties or responsibilities relating to children) should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review ('Cases of Concern' - CFC).

The safeguarding partners should promptly undertake a rapid review of the case, in line with any guidance published by the Panel. The aim of this rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review

As soon as the rapid review is complete, the safeguarding partners should send a copy to the Panel. They should also share with the Panel their decision about whether a Local Child Safeguarding Practice Review (LCSPR) is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate. They may also do this if, during the course of a LCSPR, new information comes to light which suggests that a national review may be appropriate. As soon as they have determined that a LCSPR will be carried out, they should inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.

Gloucestershire Safeguarding Children Partnership

5. Criminal investigation/Prosecution

Where a Safeguarding Adults Review is to take place and there are to be criminal proceedings, the Local Safeguarding Adults Board and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information. This can be found on the CPS website: https://www.cps.gov.uk/national-protocols-and-agreements-other-agencies

The framework deals with the process of a Safeguarding Adults Review and how it may affect the conduct of the criminal investigation/prosecution.

Appendix 7 – Guidance for staff about Safeguarding Adult Reviews

1. **Who will speak to me, and why?**
This will be dependent upon the approach used to review the case. It could be a manager from your agency appointed to write the agency management review report (IMR – Individual Management Review undertaken by each agency).

They will ask you to expand on information contained in files or to clarify what you have recorded. This interview generally focuses on facts and actions, and the person speaking to you will not question you directly on issues of your performance, as this is a matter for your managers. Notes will be taken of the questions asked and responses received.

Safeguarding Adults Reviews (SARs) enable all partner agencies to identify any lessons that can be learned from particularly complex or difficult safeguarding adult cases and implement changes to improve services in the light of these lessons

Note: People undertaking SARs have a duty to report any concerns about practice or risk to adults or children that may become known in the course of review.

2. **Can I bring someone with me to the interview/conversation/discussion?**
You can bring a colleague or other supportive person with you if you wish.

3. **What happens to the information I give?**
It is noted down. The notes are for use by the report author, to assist in compiling an accurate account of the agency's actions. They would not be shared with other agencies or be appended to any other report.

Note: Although great care is taken to avoid identifying individual staff by name in reports, it is sometimes the case that staff may be identified by some other means, such as being named by the service user, or simply by being the key worker for the case.

Any report produced for the purposes of a SAR must look openly and critically at individual and agency practice and you will be held accountable for your own actions in the case. However, at the end of the SAR process, it is the agency that is held accountable for all the actions taken by its staff, and they must address all issues of concern, such as practice and performance issues of staff, training and policy deficits.

4. **How will I be kept informed of what is happening in the case?**
4.1 Information: your agency representative (usually a Senior Manager) is responsible for keeping staff informed, where appropriate and relevant, of what is taking place in the Review process.

4.2 Support: your Manager should also have relevant information and will assist and support you as required. Depending on the circumstances of the case, it is possible that another person will be appointed to the role of providing support and information instead of your Manager.

4.3 Managerial follow up: when the report has been completed, you will be able to read

it, and suggest amendments or corrections. You will have the chance to reflect on the learning that has been identified. You should be able to contribute to the recommendations that are made.

Good practice: This will be identified in the SAR and shared with others in your agency.

Feedback: at the end of all the formal processes, when the SAR has ended, feedback will be given to you and other staff. This may be done on an individual basis, for example where interviews have taken place, or in groups i.e. SAR learning events.

The Action Plan that must be implemented across agencies will also be shared with staff.

Appendix 8 – Safeguarding Adult Review Quality Markers

Click on the following link:
[Safeguarding Adults Review Quality Markers - SCIE]