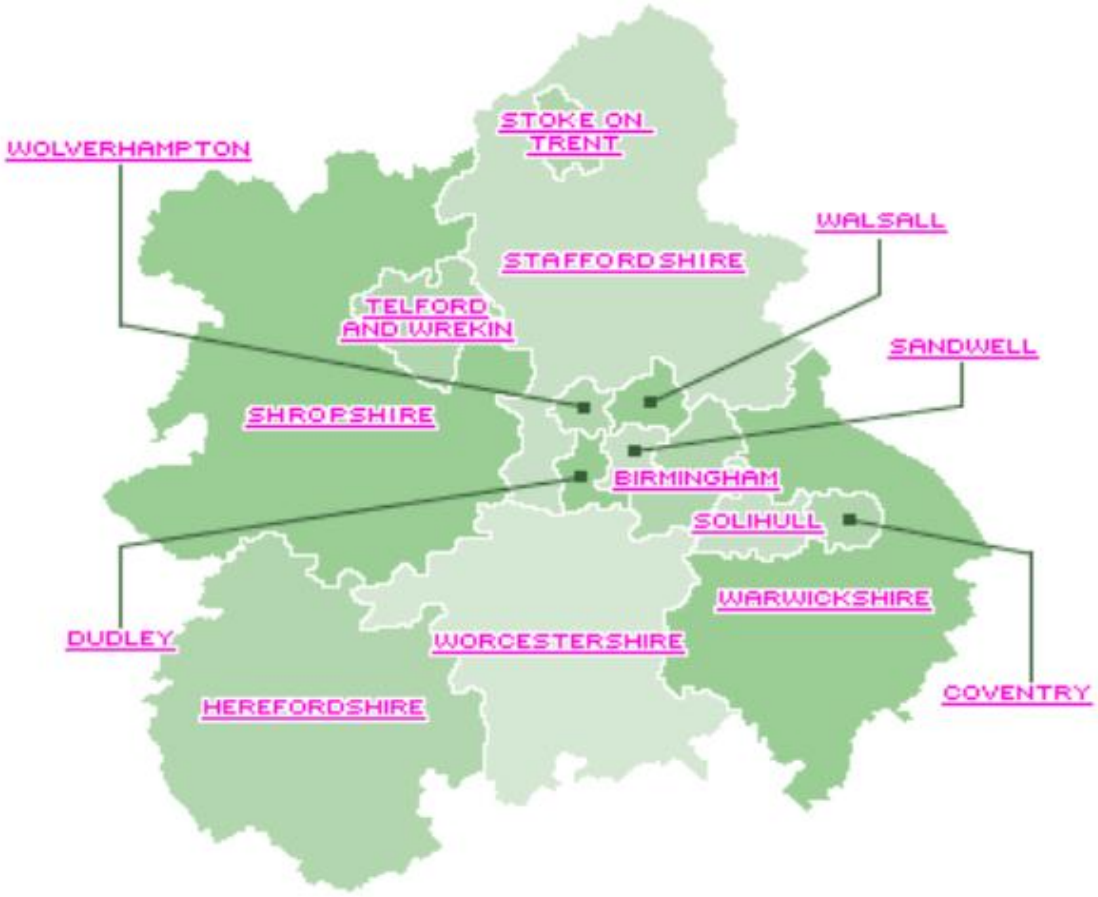
WEST MIDLANDS
REGIONAL ADULT SAFEGUARDING LEADS
DEVELOPING POLICIES AND PRACTICE ACROSS THE REGION

West Midlands Regional Safeguarding Adult Review (SAR) Guidance



Version: Final December 2025
Date of Issue:
Document owners: West Midlands Adult Safeguarding Regional SAR Group

Contents

1. Introduction

The Care Act 2014 places a statutory duty on Safeguarding Adults Boards (SABs) to undertake Safeguarding Adults Reviews (SARs).

This guidance aims to ensure a consistent and robust approach to the process and practice in undertaking SARs that follows both statutory guidance and local policy and provides a framework which enables SARs to be undertaken in an effective, timely and proportionate way with the primary aim of multi-agency learning.

This guidance is a Pan West Midlands document and should be read in accordance with:

- West Midlands Multi-Agency Adult Safeguarding Policy and Procedures
- Local Board Procedures
- SCIE- SAR Quality Marker checklist

2. SAR Criteria

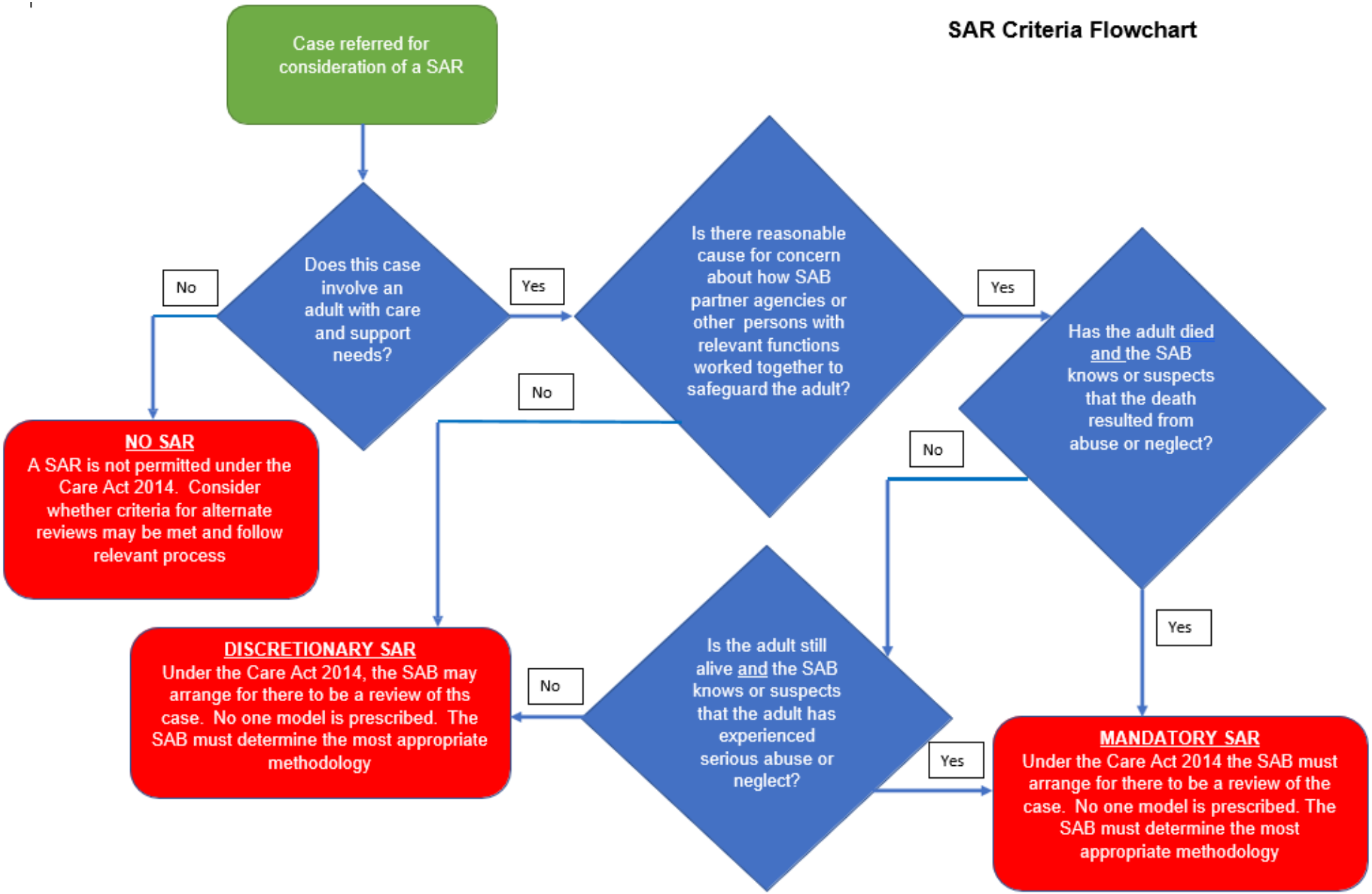
Section 44 of the Care Act 2014 outlines the circumstances in which Safeguarding Adults Boards (SABs) must undertake a SAR (mandatory SAR) when:

- An adult in its area dies as a result of abuse or neglect, whether known or suspected; or
- Where the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect; and
- There is concern that partner agencies could have worked together more effectively to protect the adult.

The Care Act also states that SABs can arrange for a SAR to be commissioned in any other situation where the criteria are not met, but it is clear that there are valuable lessons to be learnt with the aim of improving how agencies work together, to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future (discretionary SAR).

The person referred for a SAR must have care and support needs; however, these do not need to be met by any statutory or other agency.

SAR Criteria Flowchart



3. Decision Making, Leadership and Governance

In making a decision about whether to undertake a SAR and of what kind, SABs must ensure that the decision is defensible paying attention to the Care Act 2014 and Making Safeguarding Personal (MSP) principles and ensure that the SAB member agencies have had an opportunity to contribute.

SABs are required to ensure that decision-making is lawful, reasonable and rational. Decision-making should be timely once individuals and agencies involved in the case have been consulted and all relevant information considered. Reasons for decisions should be recorded. Decision-making can be challenged in the High Court by way of judicial review or investigated by the Local Government and Social Care Ombudsman.

Please check individual SAB local procedures / toolkits for information about local governance arrangements.

Governance: QM6 considerations not already covered in the paragraph above.

QM6, those with ultimate accountability, lists 12 factors to consider as the SAR progresses. These refer to matters of leadership, oversight and accountability and include timeliness, organisation engagement, family involvement, quality assurance, challenge (factual accuracy), consultation, handling of disagreements etc.

Review authors will ensure that organisation representatives have the appropriate level of seniority to be involved in the SAR. They will also identify escalation routes – including how to raise concerns about delays to the review process. Any reasons for delay will be fully recorded.

Those with ultimate accountability (Chair of the Board / The Board) must make themselves available to provide leadership in addressing any issues that arise during the SAR. Senior leads of statutory partners will deliver clear messages that how the SAR is conducted is important and will ensure that people are cared for, and relationships fostered through the process.

4. Purpose

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

SARs should help to achieve understanding for individuals, families and friends of adults who have died or been seriously abused or neglected.

The purpose of the reviews is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs, their response will be defensive, and their participation guarded and partial.

This document has been cross-referenced with the Social Care Institute of Excellence (SCIE) Quality Markers for SARs.

5. Principles and Process

The following principles apply to all reviews:

- The individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.
- Professionals/practitioners should be involved fully in reviews and invited to contribute their perspectives.
- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Safeguarding Adult Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- The Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practice.
- The judgement should make meaningful reference to the principles of Making Safeguarding Personal and 6 core safeguarding principles (as outlined in Section 14.13 Department for Health and Social Care's Care and Support Statutory Guidance).
- Consideration must be given to any impact that changes in key personnel has on the SAR.
- Administrative support and reviewer capacity should match expectations about the quality and timing of the SAR.

- Feedback on the SAR process should be encouraged, considered and addressed in real time.
- Any known sensitivities, tensions or conflicts are to be shared with the reviewer.
- Roles and responsibilities in the SAR process will be made clear at the initial review meeting.

6. SAR Methodologies and Commissioning

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. Methodology is not prescribed in the Care Act 2014, and this enables flexibility to consider a range of options.

No one model or methodology will be applicable for all cases, the SAB will need to weigh up what type of 'review' process will allow the SAR to fulfil its purpose of illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities. When considering a methodology, it is also important that consideration is given to how the SAR will cover the range of relevant positions and perspectives, including all parts of the multi-agency system, both operational and strategic.

In parallel to selecting the methodology and drafting the TOR, the SAB Business Manager will support the commissioning process and will act on behalf of the Board to provide support and oversight to the contractual arrangements with the Independent Reviewer.

A lead reviewer, who has had no previous involvement in the management of the case and no conflicts of interest will be appointed for each SAR.

Consideration should be given to the reviewer's experience and expertise in this area, to ensure that they have the appropriate skills and be able to lead a SAR process.

The reviewer should be able to produce a SAR report which fulfils the terms of reference for the review and is compliant with the SAR Quality Markers.

7. Duty of Candour

All members of a SAB and/or their staff are expected to have a culture of openness, transparency and candour within their day-to-day work and with the SAB including any SARs undertaken. In interpreting this "duty of candour", we use the definitions of openness, transparency and candour used by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

As a member of the SAB all agencies have a responsibility to ensure it is open and transparent with the SAB when certain incidents occur in relation to the care and treatment provided to people who use their services and ensure that their staff understand their responsibility to report all incident that meet the criteria for a SAR. The SAB will routinely assure itself that mechanisms are in place to respond to single and multi-agency concerns.

Every agency has a responsibility for identifying own learning and multi- agency learning.

A SAB may request a person to supply information to it or to another person. The person who receives the request must provide the information to the SAB if:

- the request is made in order to enable or assist the SAB to do its job.
- the request is made of a person who is likely to have relevant information and then either:
- the information requested relates to the person to whom the request is made and their functions or activities

For further information please refer to section 45 Care Act 2014 and paragraph 14.186 of the Care Act Guidance

This statutory duty should be clearly communicated to all agencies requested to provide information. Any non-compliance of information sharing should be considered and addressed at the earliest opportunity and should issues persist these should be escalated using the SAB's escalation pathway. The SAB should make mindful requests for information bearing in mind the need to be proportionate, the value of the information to the SAR and, wherever possible, should seek to reduce the demands on all participants. The SAB should be clear who owns documents generated through the SAR, this should be included on the index of documents, so that the relevant body can make judgements on their disclosure.

8. Cross Boundary SARs

SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent

harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

9. SARs and Childhood Experience of Abuse

SARs should be undertaken in accordance with the criteria identified above and focusses on a person's experience of abuse as an adult.

It is acknowledged that there will be cases where adults have moved from Childrens to Adult Services and their predominant experience of abuse happened before the age of eighteen. Early consideration should be given to identifying the most appropriate route for responding to the concerns raised for example, historic child abuse may be more appropriately dealt with by the Police or reviewed by Local Childrens Safeguarding Partnerships (LSCP).

Boards and organisations should cooperate across reviews and requests for the provision of information should be responded to as a priority.

Appendix 2 provides more information about the interface with other reviews.

10. Links with Other Reviews

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both Child Safeguarding Practice Review (CSPR) and a Domestic Homicide Review (DHR) / Domestic Abuse Related Death Review (DARDR). Where such reviews may be relevant to SAR (for example, because they concern the same perpetrator), consideration should be given to how SARs, DHRs / DARDRs and CSPRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case. For example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

In setting up a SAR the SAB should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Practice Review (CSPR) or Domestic Homicide Review (DHR) / Domestic Abuse Related

Death Review (DARDR), a criminal investigation or an inquest. This should take place at the earliest opportunity possible.

It may be helpful when running a SAR and DHR / DARDR or CSPR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. QM5 states that each review run in parallel should have their own Terms of Reference. Any SAR will need to take account of a coroner 's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the manager of the SAR to ensure contact is made with the Chair of any parallel process to minimise avoidable duplication.

Consideration should also be given to ensure that there is no prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and the relevant family members. Consideration should be given to the retention of notes of interviews and meetings as well as copies of reports that might be relevant to the criminal proceedings. An index of materials generated by the SAR should be maintained so that it can be readily considered to see if it is able to be disclosed.

11. Analysis

Analysis should be undertaken ensuring that it seeks out causal factors and systems learning but should also seek to identify areas of good practice that may need to be replicated in other areas. It should show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice. Techniques should be used that ensure that bias is kept to a minimum and which allow a transparent working out of conclusions in order for these to be critiqued. The analysis should be undertaken against a backdrop of the most up to date research in respect of good practice.

12. The Report

SAB members should ensure that the report achieves its commissioned specification, captures the learning for organisations or partnerships and also that provides insight into factors that may prevent or hinder individuals from being safeguarded. The SAB members should also ensure that the level of details in the report satisfies the need for privacy by the adult or their family.

The final SAR report should outline:

- A sound analysis of what happened.
- Any errors or problematic practice and/or what could have been done differently.

- Why those errors or problematic practice occurred and/or why things were not done
- differently.
- Which of those explanations are unique to this case and context, and what can be
- extrapolated for future cases to become findings (system findings).

As set out in the Care and Support Statutory Guidance, all SAR reports "should be written in plain and easy to understand language.... and contain findings of practical value to professionals and organisations including what action needs to be taken to prevent a recurrence".

In Michael Preston Shoot's research Analysis of SAR's 2017-2019 he states 'The best reports demonstrated good concordance between the issues identified through analysis of key episodes or events and recommendations, made explicit use of the six adult safeguarding principles, and detailed how the SAB would be expected to monitor the actions arising from the SAR. The best reports were structured to illuminate findings, learning points and recommendations that clearly flowed from the case chronology and analysis, with sufficient examples to demonstrate what enabled and what obstructed positive practice, and what challenged the practitioners and services involved and their response. The best reports drew on advice from experts and specialists, and drew in learning from other SARs, research and theory to underpin and reinforce the emergent learning. The best reports concluded the analysis and linked the findings and recommendations back to the terms of reference. The recommendations were SMART and CLEAR where the latter refers to recommendations that have established the case for change, are learning oriented, evidence-based, with responsibility assigned and review planned.'

SARs should specify the nature of abuse or neglect and take into account how the adult's lived experience—including aspects such as race, culture, ethnicity, and other protected characteristics as defined by the Equality Act 2010—may have influenced case management. It is also essential to safeguard the privacy of the individual's family.

13. Publication

Upon the SAB formally agreeing the SAR, the Board will consider the publication and media strategy for the report. The SAB retains discretion over all aspects of publication, including timing of the publication and to take into account any mitigating factors, such as ongoing parallel proceedings, confidentiality or other legal reasons.

It may be necessary to delay the publication of reports in some circumstances, for example, pending the conclusion of a criminal investigation or coronial inquest. However,

the SAB will ensure that in the interim agencies progress with implementing the recommendations from the action plan produced from the SAR report.

Any reports to be published must be fully anonymised unless the adult(s) and/or family members or their representatives agree that the adult(s) first, last or both names can be used. In any event the decision to anonymise the report if this is deemed to be necessary rests with the Independent Chair.

In the spirit of sharing learning, the SAB will always aim to publish reports in full but has a power not to publish should the circumstances of the case identify specific risk for which it would not be appropriate for the report to be in the public domain. In such situations, consideration will be given to publishing an executive summary rather than the full report.

Reports will be published on the SAB website. Every SAR undertaken within the past year will be summarised in the SAB Annual Report.

All SARs will be submitted to the National SAR Library and the **West Midlands SAR Repository**

Any media and communication issues will usually be coordinated by the Council's Communications Team. This will be done in collaboration with Communications Teams of other relevant agencies involved, alongside agreed representatives of the Board. The SAB Independent Chair will release a press statement where appropriate.

14. Improvement Action

The SAB should ensure that it enables robust, informed discussion and agreement by agencies of what action should be taken in response to the Safeguarding Adult Review (SAR) report. Decisions should be made in respect of individuals, agencies or forums who are able to tackle the systems findings raised and consideration should also be given to which factors can best be addressed locally, regionally or nationally.

If there are issues that arise from Local SARs that require a national response the escalation protocol will be followed. Those concerns will be forwarded to the WM regional SAB Chairs network in the first instance.

15. Resolving Disagreements

If local agreement cannot be reached on the requirement for a SAR to be undertaken, then the Safeguarding Adult Board should refer to its dispute resolution agreement.

As a last resort a complaint can be made to the Local Government Ombudsman if the complainant:

- Disagrees with SAB decision to not undertake a safeguarding adult review.
- Unhappy with decision of a SAB or outcome of a safeguarding adult review.
- Makes a complaint is about the makeup of the SAR and potential conflict of interest.
- Is concerned the Chair of the SAB is also the chair of the SAR; or
- Is unhappy with the conduct of a professional on an SAB who is employed by a body that falls outside the LGO's jurisdiction.

16. Retention

The retention period for SARs including the report, executive summary and supporting information can be found in the local SAB SAR guidance document.

17. References

- Care Act 2014
- Department of Health and Social Care (October 2018) Care and Support Statutory Guidance – issued under the Care Act 2014.
- Social Care Institute for Excellence (2015) Safeguarding Adults Reviews under the Care Act – implementation support.
- ADASS Safeguarding Adults Policy Network – Guidance - June 2016
- Out-of-Area Safeguarding Adults Arrangements - Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements
- London Joint Improvement Programme: Learning from Serious Case Reviews on a Pan London Basis, Sue Bestjan, March 2012
- SCIE / RiPfA Safeguarding Adult Review Quality Markers checklist March 2022
- Coventry Safeguarding Adults Board – Safeguarding Adults Review Toolkit
- Dudley Safeguarding Adult Board – SAR Policy
- Herefordshire Safeguarding Adults Board Adults Policies & Guidance - Herefordshire Safeguarding Boards and Partnerships
- Sandwell Safeguarding Adult Board Procedures and Practice Guidance
- Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Safeguarding Adult Review Protocol
- Telford and Wrekin Telford and Wrekin safeguarding partnership
- Warwickshire Safeguarding Board: WS SARs Protocol and Guidance
- Worcestershire Safeguarding Adults Board Safeguarding Adults Review Protocol January 2016

Appendix 1 – SAR Methodologies and Checklist

1. Rapid Reviews

This methodology is based on the Children's Safeguarding Practice Review process as set out in Working Together to Safeguard Children 2023.

The aim of the 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 the adult's safety and share any learning appropriately
- Consider the potential for identifying improvements to safeguard and promote the welfare of the adult;
- Decide what steps they should take next, including whether or not to undertake a Safeguarding Adult Review

Upon receipt of a notification which may meet the criteria for a Safeguarding Adult Review, a multi-agency rapid review meeting is called to consider the case. Scoping and analytical chronology requests are sent to all partners involved to gather facts about the case and determine the extent of agency involvement with the adult. Partners are asked to return information to the business unit to review responses and consider key lines of enquiry prior to the rapid review meeting. Please see local guidance for any timescales to be adhered to.

During the rapid review meeting the information gathered to date is considered and the case is reviewed against the SAR criteria, initial learning points are established, and any further actions agreed. The partners then record a decision on whether there is further merit in progressing to a more detailed review or whether the learning has already been established.

If the rapid review is thorough, it can in some cases, obviate the need for further review and enable areas to move quickly to implement the learning across the system.

2. Traditional Review Methodology

This model is traditionally used where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

<u>This model includes</u>

- The appointment of panel, including a Chair (who must be independent of the case) and core membership-which determines terms of reference and oversees process.
- Appointment of an Independent Report Author to write the overview report and summary report.
- Involved agencies undertaking an Individual Management Review outlining their involvement, key issues and learning.
- Chronologies of events.
- Formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships.
- Publishing the report in full.

The benefits of this model are:

- It is likely to be familiar to partners.
- Possible greater confidence politically and publicly as it is seen as a tried and tested methodology.
- Robust process for multiple, or high profile/serious incidents.

The drawbacks of this model are:

- Methodology stems from children's arena so process to adults is not so familiar.
- Resource intensive.
- Costly.
- Can sometimes be perceived as punitive.
- Does not always facilitate frontline practitioner input.

3. Action Learning Approach

This option is characterised by reflective/action learning approaches, which does not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments. There is integral flexibility within this approach which can be adapted, dependent upon the individual circumstances and case complexity.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE)-Learning Together Model
- Health and Social Care Advisory Service (HASCAS)
- Significant Incident Learning Process (SILP)

Although embodying slight variations, all of the above models are underpinned by action learning principles.

The broad methodology is:

- Scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- Appointment of facilitator and overview report author
- Production/review of relevant evidence, the prevailing procedural guidance, via chronology, summary of events and key issues from designated agencies
- Material circulated to attendees of learning event; anticipated attendees to include: members from SAB; frontline staff/line managers; agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- Learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learnt
- Consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- Event to consider first draft of the overview report and action plan
- Final overview report presented to Safeguarding Adults Board, agree dissemination of learning, monitoring of implementation
- Follow up event to consider action plan recommendations
- Ongoing monitoring via the Safeguarding Adults Board

The benefits of this model are:

- Conclusions can be realised quicker and embedded in learning
- Cost effective
- Enhances partnership working and collaborative problem solving
- Encompasses frontline staff involvement
- Learning takes place through the process enhancing learning.

The drawbacks of this model are:

- Methodology less familiar to many
- Events require effective facilitation
- Specific versions such as SCIE Learning Together and SILP are copyrighted

4. Individual Agency Review

This model would be relevant when a serious incident identifies just one agency involvement, or one agency learning identified – there are no implications or concerns regarding involvement of other agencies, and it is appropriate that lessons are learnt

regarding the conduct of an agency and in the absence of the need for a multi-agency review.

Such reviews could be requested by the SAB or if undertaken individually by an agency they should inform the Board they are undertaking an Individual Agency Review with a safeguarding element, for the Board to consider any transferable learning across partnerships.

Circumstances when this model might be appropriate:

- Serious Incidents.
- Implications relate to an individual agency, but lessons could be shared, applied and learnt across the partnership.
- Where serious harm and/or abuse was likely to occur but had been prevented by good practice (positive learning).

The benefits of this model are:

- Provides an opportunity for learning from an individual agency.
- Enables individual agency scrutiny into a specific area.
- Assists a 'Duty of Candour'.

The drawbacks of this model are:

- Can be seen as outside the SAR purpose of multi-agency learning.
- Risks individual agency opposition.

5. Peer Review Approach

A peer review approach encompasses a review by one or more people who know the area of business. This approach accords with self-regulation and sector led improvement programs which is an approach being increasing used within Adult Social Care.

Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

There are two main models for peer review:

- Peers can be identified from constitute professionals/agencies from the Safeguarding Adults Board members or
- Peers could be sourced from another area/SAB which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.

The benefits of this model are:

- Increased learning and ownership if peers are from the SAB.
- Objective, independent perspective.
- Can be part of reciprocal arrangements across/between partnerships.
- Cost effective.

The drawbacks of this model are:

- Capacity issues within partner agencies may restrict availability and responsiveness.
- Skill and experience issues if SARs are infrequent potential to view peer reviews from members of a Board as not sufficiently independent especially where there is possible political or high profile cases.

6. Significant Event Analysis / Audit (SEA)

SEA is traditionally a health process to formally analyse incidents that may have implications for patient care. It is an active approach to case analysis which involves the whole team in an open and supportive discussion of selected cases/incidents.

The aim is to improve patient care by responding to incidents and allowing the team to learn from them. The emphasis is on examining underlying systems, rather than directing inappropriate blame at individuals. Such reflective practice is known by several names – significant event analysis, untoward incident analysis, critical event monitoring. The name itself is less important than the process and the outcomes derived from it.

The benefits of this model are:

- It is not a new technique – doctors have long discussed cases for educational and professional purposes.
- NHS England has published Serious Incident Framework in March 2015.

The drawbacks of this model are:

- Seen as a model that relates only to Health.

7. Case File Audit (multi or single agency, table top or interactive)

Case file audit can be a powerful driver in improving the quality of front-line practice and the management of safeguarding adult cases. The aims of case file audits are to examine records in paper case files/electronic records to establish the quality of practice and identify how practice is being undertaken. Case file audits can be single agency or multi agency.

They can be undertaken in a number of ways:

- As a table-top exercise (therefore no input from practitioners).

- Interactive with partners and or practitioners.
- Interactive with the adult and or their family.
- Proactively as suggested in s44 (4) of The Care Act 2014.

The benefits of this model are:

- Flexible – in that they can be conducted in many different ways.
- Quicker learning can be achieved.

The drawbacks of this model are:

- Learning from some models will only come from written records without relevant context.

8. Root Cause Analysis (RCA)

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

9. Thematic Reviews

A thematic review can be undertaken when themes are identified from previous SARs or where several cases have met the SAR criteria, and the reviews will be undertaken together as they have a similar theme. Themes may also be identified by the Performance and Quality Assurance Subgroup. A thematic review considers an individual case or a theme as a starting point, but looks at issues raised generally, rather than the details specific to the case.

- Findings are collated from involved agencies or previous reviews
- The legal framework, risk and communication are considered
- An academic literature review is undertaken
- Policy documents are reviewed
- Interviews are held with practitioners
- Multi-agency response is considered

<u>The benefits of this model are:</u>

- Increased opportunity for wider learning
- Cost effective
- Engagement with staff and managers at different levels within organisations

<u>The drawbacks of this model are:</u>

- Workloads of those involved may create capacity issues
- Resource intensive
- Unfamiliar methodology

Checklist	
Terms of Reference *Mandatory* **Essential**	Better outcomes can be achieved if all agencies and individuals address the same questions and issues relevant to the case review being undertaken. Well formulated terms of reference are essential to ensure that the review is: • Properly scoped • Manageable • Conducted by the appropriate people • Within agreed timeframes. – To establish facts of the case – To analyse and evaluate the evidence – To risk assess – Make recommendations Ensure the review will answer "**THE WHY**" question.
Interface with other review processes ***Mandatory*** *See Appendix*	Before starting a SAR identify if there is any links to other reviews and identify which takes priority. For example: • Domestic Homicide Review (DHR) / Domestic Abuse Related Death Review (DARDR) • Children's Safeguarding Practice Review (CSPR) • Serious Further Offence Review (Probation) • Mental Health Review • Learning from Lives and Deaths (LeDeR) In addition - Consider previous SAR's – will a recent SAR reinforce the same learning or is new learning to be identified?

Family & significant others involvement ***Mandatory***	Identify the degree to which victims/families will be involved in the review and how they will be informed of this review. Victims/families (family members who have played a significant role in the life of the service user) should be notified that the review is taking place. Involvement can be:- • Formal notification only • Inviting them to share their views in writing or through a meeting. The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police. Victims/families should be offered support.
Independent Advocacy ***Mandatory***	The local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a safeguarding adult review. Where an independent advocate has already been arranged under s67 Care Act or under MCA 2005 then, unless inappropriate, the same advocate should be used. It is critical in this particularly sensitive area that the adult is supported in what may feel a daunting process.
Chair ***Mandatory***	Each SAR will require a skilled and competent Chair of the panel considering the SAR, receiving IMRs and agreeing the report and recommendations. When identifying who to chair the panel – consider: • Are they independent of the case? • In single agency reviews – are they independent of the single agency that it involves? • Do they need to be independent of the SAB? • What skills, knowledge and expertise do they specifically need?

Panel ***Mandatory***	Each SAR should be presented to a panel for scrutiny. The panel should be made up of a minimum of 3 people excluding the chair. They must be: • Independent of the IMR authors • Independent of the case • Knowledgeable of the issues/subject area.
Practitioner involvement ***Mandatory***	Practitioners will be involved in all SAR's – however the level of their involvement can be varied. The following should be considered: • Interviewing and taking a statement from practitioners for IMR's can result is staff having heightened anxiety. • Practitioners must be offered support throughout a SAR. • Identify how practitioners will be kept regularly updated with the progress of SARs and are informed of the outcome. Multi agency learning events that involve practitioners can: • Be very positive events – however such events must be skilfully chaired and managed and support should be available to staff throughout the event. • Assist practitioners to contextualize what happened and achieve closure. • Result in quicker and more enhance learning.
Experts **Optional**	Consider if an expert is required to help to fully understand the situation and IMR findings. If possible identify which expert will be needed or may be needed at the start of the process. However, experts can be called upon at any time during the process.

Overview Report & Executive Summary ***Mandatory***	An overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action must be produced. An Executive Summary may also be commissioned. All reviews of cases meeting the SAR criteria should result in a report which is published and readily available on the SABs website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to demonstrate openness, transparency and candour and to support national sharing of lessons. From the start of the SAR the fact that the report will be published should be taken into consideration. SAR reports should be written in such a way that publication will be likely to harm the welfare of any adult with care and support needs or children involved in the case. Exclusion to this rule would be single agency reviews if individuals can be identified. Final SAR reports should: • Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence; • Be written in plain English and in a way that can be easily understood by professionals and the public alike; • And be suitable for publication without needing to be amended or redacted.
Independent Author ***Optional***	In the following situations it may be beneficial to consider an author who is NOT the chair: • Very difficult and complex cases to enable the chair to concentrate in chairing • Due to the specialist nature of the subject. • To enable the chair to be from the SAB and be the chair as part of his day to day work. An independent author must be: • Independent of the case • Independent of the organisations involves • Appropriately skilled and competent. They may also be independent of the SAB.
Timescales	Wherever possible SARs should be completed within 6-months.
Chronology ***Optional***	A chronology can provide a timeline – a sequence of events. A clear chronology of events in a safeguarding case can show

	agencies where risks and can be used to cross reference significant events. If using a chronology, consider: • The timeframe • What you mean by key/significant events • Using an agreed terminology avoiding abbreviations – for example Nurse A in one organisations chronology may not be the same Nurse A in another organisation's chronology. For complex cases it is recommended a Chronolator tool is used.

Appendix 2 – Interface with other reviews

Review	Precedence
Domestic Homicide Reviews (DHR) / Domestic Abuse Related Death Review (DARDR) Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.	When the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that: the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by - **(a)** a person to whom he was related or with whom he was or had been in an intimate personal relationship, or **(b)** a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
Child Safeguarding Practice Review (CSPR) Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCPs to undertake reviews of serious cases in specified circumstances. For further guidance see –Working Together to Safeguard Children 2023	When abuse or neglect is known - or suspected - and either: • a child dies • a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child
Mental Health Reviews/Suicide Review	When a person who is in contact with mental health commits suicide, NHS boards undertake a suicide review to analyse what happened and recognise where anything can be done to make things safer for other people at risk.
Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review Criminal Justice and Court Services Act 2000 - strengthened by the	When the main purpose is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

provisions of the Criminal Justice Act 2003 (s325–327).	
Serious Further Offending Notification and Review Procedures Offender Rehabilitation Act 2014	Reviews will be required in any of the following cases: • any eligible offender who has been charged with murder, manslaughter, other specified offences causing death, rape or assault by penetration, or a sexual offence against a child under 13 years of age (including attempted offences) committed during the current period of management in the community of the offender by the NPS; or whilst subject to ROTL. In addition, this will also apply during the 28 day period following conclusion of the management of the case; or • any eligible offender who has been charged with another offence on the SFO qualifying list committed during a period of management by the NPS and is or has been assessed as high/very high risk of serious harm during the current sentence (NPS only) or has not received a formal assessment of risk during the current period of management; or • any eligible offender who has been charged with an offence, whether on the SFO list or another offence, committed during a period of community management by the NPS and the provider of probation services or NOMS has identified there are public interest reasons for a review. This may be due to significant media coverage Ministerial interest or where reputational risks to the organisation may arise; or if the offender has died and not been charged with an eligible offence but where the police state he/she was the main suspect in

	relation to the commission of an SFO.
Learning Disabilities Mortality Review (LeDeR) The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere	All deaths of people with learning disabilities aged 4 years and over will be reviewed, regardless of whether the death was expected or not, the cause of death or the place of death. The LeDeR programme is using the definition of learning disabilities provided in the 2001 White Paper "Valuing People". For more information see the briefing paper here: Briefing paper 1 - What do we mean by learning disabilities (PDF, 607kB)

Appendix 3 – Making a Good SAR Referral Guidance & Checklist

Link to Dudley guidance and checklist once reviewed and approved.

Appendix 4 – SAR Referral Form

Insert Logo

Referral for a Safeguarding Adult Review (SAR)

Criteria for Safeguarding Adult Review

[Local SAB] must arrange a SAR when:

(a) an adult* in its area dies of abuse or neglect, whether known or suspected

AND

(b) there is concern that partner agencies could have worked more effectively to protect the adult.

[Local SAB] **must** also arrange a SAR if:

(a) an adult* in its area has not died, but the SAB knows or suspects that the adult has experienced serious** abuse or neglect.

[Local SAB] **may** also

(a) commission a SAR in other circumstances where it feels it would be useful, including learning from "near misses" and situations where the arrangements worked especially well.

* Adult must be residing in the WST area and has needs for care and support (whether or not the local authority has been meeting any of those needs).

** something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Any individual or organisation working with adults should inform the relevant Safeguarding Partners[1] of any incident they think should be considered for a Safeguarding Adult Review, or other type of learning review, using this form.

Professionals should discuss the case with their agency's designated safeguarding lead/officer to help formulate the rationale. If you need advice completing this form, please contact us: our

[1] The formal Safeguarding Partners are the Integrated Care Board, Police and the Local Authority . Details of where to send this form are included at the end of the form.

phone and email address are included at the end of this form. **A referral should be made as soon as possible after the incident occurs.**

Background Information

Name of Adult:

Date of Referral:

Agency Referral[2]

Name	Agency & Job Title	Contact Details

Please give the details of the Head of Service / Line Manager / Designated Safeguarding Lead with whom you have discussed the case.

Name	Agency & Job Title	Contact Details

Section 1: Brief overview of adult to include family composition

1.1 Adult's Details

Name	
Date of Birth	
Address	
Gender	
Ethnicity	
Language	
Religion or other belief system	

[2] Please note that, as the referrer, you may be required to present the referral at the local [Review Group].

.

Sexuality	
Disability (inc. Neurodiversity)	
Name and Address of GP	
NHS No (if known)	
Names and addresses of family/advocates/ representatives/next of kin:	
Is the adult open to Adult Social Care or Mental Health (if so, who is the lead practitioner)?	
Date of Death or Incident (please specify which)	
Address of location of incident	
Is this case known to be the subject of a criminal investigation? (If so, who is the lead investigator?)	
Is this case known to be the subject of a Coroner's Inquiry? (If so, who is the key contact?)	
Have any adult safeguarding concerns been shared with Adult Social Care (If so, who is the key contact? Include details of any safeguarding referrals and meetings.	

1.2 <u>Details of Family Members and any Significant Others (includes advocates, representatives and next of kin)</u>

Name and Address	Relationship to Adult	Date of Birth	Legal Status	Ethnicity

What action has been undertaken to safeguard the adult if they are alive?

1.3 Other agencies and providers known to be involved

Agency	Contact Details: Address, Telephone and E-mail	Reason for involvement (include whether current or not)

Section 2: Case Background

PLEASE NOTE: The information you provide will be used to help establish whether the case meets the criteria for a Safeguarding Adult Review or other type of learning review.

Brief Summary of case including details of any safeguarding referrals and meetings:

Type of abuse or safeguarding issue.
What are the characteristics of the incident? Select all that apply – suspected or actual (click on box) ☐ Physical abuse ☐Sexual abuse ☐Psychological\emotional abuse

☐Financial or material including scamming
☐Discriminatory
☐Organisational abuse
☐Neglect or acts of omission
☐Domestic abuse
☐Sexual exploitation
☐Modern slavery (including trafficking)
☐Self-neglect
☐Suicide
☐Rough sleeping
☐Substance misuse
☐Criminal exploitation
☐Forced Marriage\Female genital mutilation

Or

☐Other (please state below)

Please explain why you think the case meets the SAR criteria.

Care and support needs of the person you feel is subject to SAR
Select all that apply ☐Physical support ☐Sensory support ☐Support with memory and cognition ☐Learning disability support ☐Mental health support ☐Social support (incl support for carers, substance misuse, asylum seekers, and social isolation) ☐No support reasons ☐Not known

Please use the chronology table below to outline any events <u>around the time of the incident</u>.

PLEASE NOTE: This should only include key events and DOES NOT need to be a detailed chronology at this stage.

Date and Time	Event

Please add any additional information you think may be relevant and may assist decision-making:

NOTE: THE ABOVE SHOULD FOLLOW A DISCUSSION WITH A NOMINATED MANAGER OR SAFEGUARDING ADVISOR IN YOUR AGENCY.

Section 3: Advice and Submission of this Form

The completed form should be sent to XXXX via Secure Email: XXXX

An initial multi-agency discussion will take place as a result of your referral, and you will be informed of the outcome.

Appendix 5 – Initial Scoping and Information Sharing Document

Insert Logo

Initial Scoping and Information Sharing

Potential Safeguarding Adult Review

We have received a Safeguarding Adult Review referral which may meet the requirements of s44 of the Care Act 2014. and will, therefore, be holding a Rapid Review to consider the case, as set out in the West Midlands Regional SAR Guidance.

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the adult and family. This will help the safeguarding partners decide whether to progress a formal Safeguarding Adult Review (SAR) and to determine the most appropriate method to identify and cascade learning from this case.

Contact details of individual / agency completing this form

Name	Agency & Job Title	Contact Details:

Date Completed:

Background Information

Summary of Case:

Indicative time to be looked at: *(Good practice suggests that the period examined should be limited. However, please include information from outside this period if you feel it is relevant to the case.)*

Section 1: Composition of the Adult and Family

All agencies are asked to check whether the details below match information held on their systems. Please advise of any anomalies.

Subject Adult:	
Also Known As:	
Ethnicity:	
National Health Number:	
D.O.B:	
Date of Serious Incident / Injury	
Home Address:	

Partner / Spouse:	
Also Known As:	
Ethnicity:	
National Health Number:	
D.O.B:	
Home Address:	

Please include here information about any additional family members / significant others who are not listed above

Section 2: Agency Information and Involvement

1. Provide a brief summary of your agency's involvement with the subject adult <u>and</u> the individuals listed in the family composition. *(Please focus on the key significant events in chronological order and, where appropriate, include the date of commencement and completion of service).*
2. From your agency's records are you able to confirm the following information for the individuals listed below:
Countries where subject adult and their family were born and/or have resided:
Ethnicity:

Language:

Gender (is it same or different from birth)

Sexuality

Disability (inc. neurodiversity)

Religion or other belief system:

Care Experienced

Employment status:

3. Do you consider that assumptions, bias, and/or racism may have affected your agency's response to the subject adult?

4. Brief analysis of individual or / and agency practice. *(Please identify any outstanding practice or potential learning)*.

Please also consider the following:

- How you have considered the impact of race, religion, culture, ethnicity and intersectionality when working with the adult
- Has consideration been given to the adults lived experience in response to their race, religion, culture and ethnicity.

5. Please identify any areas for concern as to the way in which partners have worked together to safeguard the subject adult.

6. Have you identified any learning and what action have you taken to implement this learning?

Please complete the action tracker template below. Please feel free to extend the table as necessary if more learning points are identified.

	Learning Point	Action Required	Lead	Target date for completion	Evidence of Progress of Implementation	RAG
1						
2						
3						
4						
5						

7. Please include any further relevant information that you wish to bring to the attention of the Rapid Review meeting.

Section 3: Advice and Submission of this Form

If you have a query about completing the form, please contact:

xxxxxx

The completed form should be returned to the following email address:

xxxxxx

A multi-agency Rapid Review will be undertaken, and you will be informed of the outcome.