Safeguarding Adults Review

Policy, Procedure &

Good Practice Guidance

March 2021

Policy, Performance and Customer Care Team

Adult Social Care | People Directorate

Contents

Policy Summary

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1.0 Policy

1.1 Introduction

The main objective of a Safeguarding Adults Board (SAB) is to assure itself that local safeguarding arrangements and partners act to help and protect adults who meet the criteria set out in Section 1 of the Care Act 2014 (implemented April 2015). Safeguarding Adults Boards are a statutory requirement under the Care Act.

Halton Safeguarding Adults Board (HSAB) oversees and leads adult safeguarding across the locality and has a range of statutory duties that contribute to the prevention of abuse and neglect. This includes the duty to conduct any Safeguarding Adults Reviews (SARs) in accordance with Section 44 of the Care Act. SARs are reviews that examine the way agencies and individuals have acted when they have been involved with an 'adult at risk'.

1.2 When should a SAR take place?

There are three broad circumstances under which the Care Act statutory guidance considers a SAR can take place (paragraphs 14.162-14.163). The guidance makes a distinction between those circumstances where the SAB **must** and **may** arrange a SAR.

1. 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.

2. SABs **MUST** arrange a SAR when:

- An adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect (e.g. the individual would have been likely to have died if not for intervention or has suffered permanent harm or has reduced capacity or quality of life either due to physical or psychological effects as a result of the abuse/neglect).

3. SABs **MAY** arrange a SAR:

- In any other siutation involving an adults in its area with care and support needs (whether or not the local authority has been involved in meeting those needs);
- To explore examples of good practice where this is likely to identify lessons that can be applied to future cases. In cases where there is learning but the case does not meet the thresholds for a full SAR, the Independent Chair may recommend a step down review in the form of an Individual Management Review.

1.3 Principles of a SAR

The SAR process is underpinned by the following principles:

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.

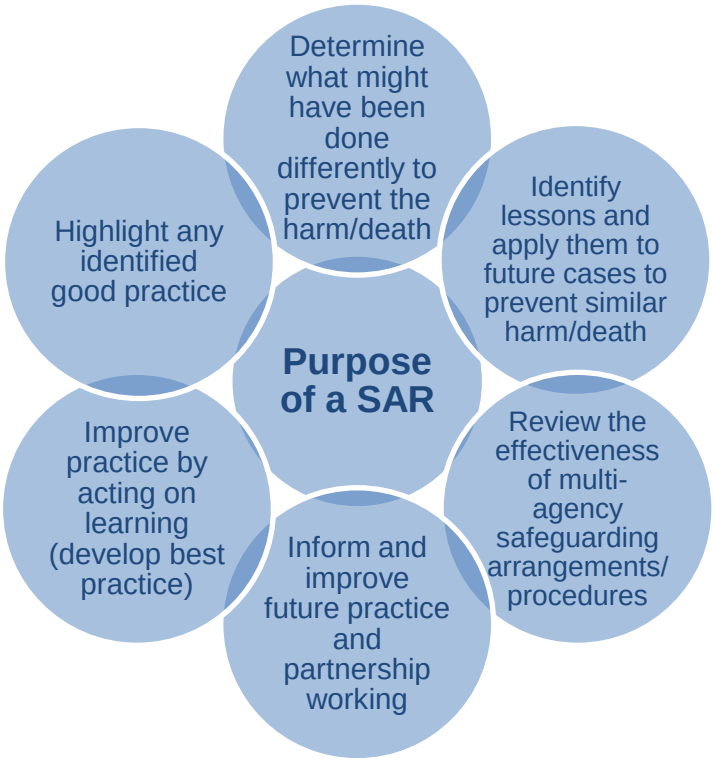
Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

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.

1.4 Purpose of a SAR

The purpose of conducting a SAR is to establish whether there are any lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.



The purpose of a SAR is <u>not</u> 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 the Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC), Social Work England and the General Medical Council (GMC).

The learning as a result of a SAR needs to be shared and the statutory Duty of Candour places a requirement on providers of health and adult social care to be open with people and their families when there are failings or things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

A SAR should highlight any lessons that can be learned from the case through a clear set of recommendations and ensure that relevant actions are taken in order to help prevent future deaths or serious harm. This helps to improve both single and inter-agency working and better safeguard and promote the wellbeing of adults at risk.

2.0 Procedure

2.1 Making a referral for a SAR

The following should be considered when deciding whether to make a referral for a SAR:
The concerns must relate to a person with needs of care and support, whether or not 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 systematic failings relating to multiple organisations and so there is potential to identify to improve multi-agency practice and partnership working.
The family should be informed of the concerns and that a Safeguarding Adult Review referral is planned and so providing an opportunity for them to give their views about the referral and to discuss how they might want to be involved.

Only Halton Safeguarding Adults Board (HSAB) can commission a SAR in Halton. However, any agency or individual can refer a case for consideration of whether it meets the criteria for a SAR. All agencies should have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning and this policy is not intended to duplicate or replace these.

Where any individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they should

refer the case to the Chair of HSAB to consider if a SAR is required. Prior to making a referral, professionals working with adults at risk should consider the relevant guidance and discuss with their organisation's line manager or SAB representative.

By virtue of the criteria, in cases where a SAR may be initiated, a safeguarding concern and/or enquiry may already have been made. Consideration of whether a SAR is required should never delay the raising of a safeguarding concern and the adherence to the Inter-Agency Safeguarding Adults Policy, Procedure and Good Practice Guidance, which considers any immediate protection required. However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have committed suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

A referral is made by completing a **referral form**. Referrals should be made as soon as it is apparent to the agency/organisation that they believe the SAR criteria has been met. An unreasonable delay in raising any issue can impact on the process and the key purpose in a number of ways.

See appendix 1 for the SAR Referral Form.

The SAB will not review cases that are more than 12 months old, unless there is significant information that has recently emerged, or there are good reasons why the SAR was not appropriate at an earlier stage. The decision to take on cases that go outside the time limit, would need to be referred to the Chair of HSAB for a final decision.

2.2 Decision making

On receipt of a SAR referral form, the Chair of HSAB will consider the information provided on the completed referral form. The Chair may seek further information including clarity about any parallel investigations that may be taking place.

The Chair of HSAB will make the **final decision** about whether a SAR should take place. On making the decision, the HSAB will write to the referrer and advise them of the outcome. In circumstances where the Chair of HSAB decides not to progress further with a referral at this stage, the reasons for this will be recorded and a response and explanation will be provided to the referrer.

See appendix 2 for the SAR Decision Process Flow Chart.

If the Chair of HSAB decides that a SAR should take place, there are two levels of SAR which can be utilised:

Level 1: Statutory SAR	Situations in which the SAB **must** conduct a SAR.
Level 2: Discretionary SAR	Situations in which the SAB **may** conduct a SAR.

The **review methodology** to be used will not be pre-determined by the level of SAR utilised but rather after consideration of the particular circumstances of each case. In any SAR, the approach should be proportionate to the scale and complexity of the issues and the potential for learning.

In any instance where the Chair of HSAB has decided a SAR should not take place, the reasons must be recorded and shared with the referrer and HSAB. However, it may be decided that there is still learning from the incident and, in this case, an **Individual Management Review** may be requested (please see appendix 3 for more information). Learning from this review should still be disseminated and shared across HSAB agencies and any other relevant regional or national networks.

2.3 Commissioning a SAR

The Care Act guidance states that SABs should aim for completion of a review within a reasonable period of time and in any event within six months of initiating it, unless there are good reasons for a longer period being required.

On confirmation of the Chair of HSAB's decision to undertake a SAR, the Chair, Director of Adult Social Services and HSAB co-ordination staff will liaise in order to make the necessary arrangements. This will include:

- Notifying the referring agency, SAB members and other interested parties (including CQC and the Coroner);
- Setting up a Safeguarding Adults Review Panel;
- Identifying appropriately qualified and experienced leads (Chair, facilitator, author as required) identifying and securing the necessary support and budgetary requirements;
- Notifying the adult and/or their family as appropriate;
- Considering an initial scope and timescales;
- Initiating any information requests that are required;
- Considering media and communication strategies;

Once the decision has been communicated, each agency will be responsible for taking appropriate actions that may be necessary in relation to the security of their records. No member agency should comment publicly upon the case without express agreement of both their senior management team and the Chair of HSAB.

2.4 SAR process

The SAR is overseen by HSAB, which is a multi-agency partnership with senior management representation from all of the key agencies who work with adults at risk in the borough. The HSAB is responsible for ensuring that effective systems are in place for the effective completion of SARs, for decision making in respect of

commissioning reviews, formally accepting reports and agreeing sign off of the report for publication. In most cases, a SAR Panel will be required to undertake and oversee the review and report to the SAB on a regular basis. The SAR Panel should be selected on the basis that they had no immediate line management of the case under review, and should normally include representatives of the three SAB statutory agencies (Local Authority, Police and Clinical Commissioning Group). The panel and associated arrangements should be proportionate to the circumstances of the case and the review methodology.

The SAR Panel will set their own meeting schedule and timings appropriate to the case and the methodology; and report this to HSAB. Whilst the frequency and number of meetings may vary, the SAR Panel will in most instances progress through the following three stage process, in order to establish, monitor and finalise the review:

Stage	Processes / actions
Stage 1	The Panel will have responsibilities from the outset to: • Specify the Terms of Reference (see appendix 4 for an example/template); • Set timescales, if not already determined; • Confirm the lead roles such as Chair, Facilitator, Author and the planned methodology to be used; • Links to other interested parties such as the Crown Prosecution Service or Coroner; • Co-ordinate and compile the available information including chronologies (see appendix 5 for a chronology template) and reports of investigations that may have taken place; • Confirm the agencies and the people involved and affected; • Identify, inform and establish links to any other processes ongoing or planned; • Where required, request that Independent Management Reviews are completed; • Identify any additional reports, information or evidence required; • Agree the nature and extent of expert or legal advice required.

Stage	Processes / actions
Stage 2	During this phase the following functions are likely to be required of the Panel (with flexibility according to the methodology used and proportionate to the circumstances): • Maintain links with interested parties and parallel investigations; • Produce a comprehensive chronology that covers that critical period collated from all agencies; • Receive and scrutinise additional reports including IMRs and safeguarding/serious incident investigations; • Cross reference information within the reports, identify any omissions or discrepancies; • Conduct/commission any further enquiries; • Examine and identify relevant action points; • Form a view on practice and procedural issues; • Identify critical points and actions with any key lines of enquiry; • If the methodology requires a workshop or learning event, then this will be planned and delivered; • Develop a framework for the report and consider drafts; • Review progress and timescales and report to the SAB.
Stage 3	During this stage, the members of the SAR Panel will discuss and agree the key learning points of the review, the recommendations and actions required; and finalise the report. Some of this work may be able to be undertaken outside of meetings, in which case panel members must commit to prioritise input and feedback to reports that are circulated within timescales. On completion, the SAR report will be presented to the HSAB which will: • Ensure contributing agencies have the opportunity to confirm the accuracy of facts and interpretation of their involvement in the report; • Confirm the recommendations from the report; • Confirm action plans, which should be endorsed at senior level by each organisation and agree accountability; • Confirm to whom the review or parts of the review are to be made available (decisions on publishing will have been taken before completion of the review); • Commissioning the dissemination of the review of key findings to interested parties including feedback and debriefing to staff, family members and media; • Confirm the arrangements to ensure that the actions are monitored and updates requested from agencies; • Sign off the action plan when complete.

The HSAB will normally exercise its function of oversight of the actions via the SAR Panel. The SAR Panel should ensure that identified actions are completed and any barriers or slippage in achieving outcomes are responded to.

If HSAB requests information from an organisation or individual who is likely to have information which is relevant to the functions of the SAB they **must** share what they know with the SAB in accordance with the Care Act 2014.

The SAR will be undertaken by people who are independent of the case under review and of the organisation whose actions are being followed. The core skills and experience expected of a reviewer/author are as follows:

- Appropriate level of seniority;
- Strong leadership and ability to motivate others;
- Inclined towards promoting an open, reflective learning culture;
- Expert facilitation skills;
- Experience of more than one review methodology;
- Good analytical skills and experience of collaboration problem solving;
- Ability to manage potentially sensitive and complex group dynamics;
- Excellent interpersonal skills;
- Safeguarding experience and understanding of vulnerability and its impact.

When undertaking the SAR, records will be anonymised. Involved organisations will be provided with copies of reports for comments on factual accuracy prior to final draft. Where a SAR Panel is established it will be the role of the panel to ensure the report is factually accurate and based on the evidence gathered during the process.

The SARs must be completed in a timely manner. Once the decision to commission a review has been made, the review should be completed within six months or if otherwise, this would need to be agreed by the Chair of HSAB. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Chair of HSAB. It is acknowledged that where a safeguarding adult review relates to serious organisational abuse or where multiple perpetrators are involved, such reviews are likely to be more complex and therefore may require a longer time period to complete.

See appendix 6 for an overview of the SAR process described above.

2.5 Joint reviews

Where there are possible grounds for a Safeguarding Adults Review and a Domestic Homicide Review or Children's Serious Case Review, Multi-Agency Public Protection Review, Mental Health Service Review and/or other such formal review processes to be undertaken jointly, then a decision should be made at the outset by the decision makers involved as to which process is to lead, who is to take which role and who is to Chair with a final joint report being taken to the necessary commissioning bodies.

Whether some aspects of the reviews can be commissioned jointly may be considered so as to reduce duplication of work for organisations involved.

Similarly, health services carry out Serious Incidents Requiring Investigation (SIRI) and any relevant investigation should be shared with the SAR Panel so that resources and information are made best use of. Serious incidents in the NHS include:

- Acts and/or omissions occurring as part of the NHS funded healthcare (including in the community) that result in unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death and homicide by a person in receipt of mental health care within the recent past;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user, or serious harm.

In setting up a SAR, HSAB should also consider how the process could dovetail with any other relevant investigations that are running parallel, such as a Child Safeguarding Review or Domestic Homicide Review, a criminal investigation or an inquest.

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 impacting on timescales. It will be the responsibility of the Chair of the SAR Panel to ensure the necessary contacts are maintained with appropriate people.

2.6 Learning from a SAR

In a SAR there is a need to achieve an understanding 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 weren't done differently;
- Which of those explanations are unique to this case and context and what can be extrapolated for future cases to become recommendations for learning;
- Any remedial action that needs to be taken in relation to the findings to help prevent similar harm in future cases.

A quality assurance process should aim to build on rather than duplicate the work already completed in the course of a review and should understand the analytic techniques and tools that form part of the particular model being used and the content of any supervision provided as part of that model.

3.0 Good Practice Guidance

3.1 Independent advocacy

The Care Act states that an independent advocate must be arranged (where necessary) to support and represent an adult who is the subject of a SAR, if it is judged they would experience substantial difficulty in participating in the review process. Where an independent advocate has already been arranged under the Care Act or under the Mental Capacity Act 2005 then, unless inappropriate to do so, the same advocate should be used.

A person assessed as having capacity to make decisions about their care and support may be offered the support of an independent advocate if they would experience 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent them and support them. It will be the responsibility of the local authority to arrange and fund advocacy support in these circumstances.

3.2 Responsibilities to the family

See appendix 7 for SAR Guidance for Families.

It is vital that families are made aware that the review is taking place and offered the opportunity of contributing to the review process. The Chair of HSAB will contact the family and carers of the adult at risk, as they think is reasonable, to invite them to participate in the review process. However, their consent is not required for the review to go ahead. They should be kept updated at key stages of the review and notified of the publication of the report.

Reflecting the principles of openness, transparency and candour, the SAB must ensure there is appropriate involvement in the review process of people affected by the case including where possible the victims of abuse and their families/significant others. In accordance with the Care Act 2014, where an adult has 'substantial difficulty' in participating, this should involve representation and support from an independent advocate (please see previous section).

The SAR Panel needs to consider the degree to which the adult, advocate and/or their families will be involved in the review. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. Consideration should also be given to if and how the known abuser might have some input to the review process.

Normally, individuals should be notified that the SAR is taking place. Involvement may be by formal notification only or by inviting them to share their views in a way that suits them. The timing of such notification is crucial and particularly where there is criminal justice processes running parallel and decisions will need to be taken in consultation with relevant parties.

If a decision is taken to not involve the adult at risk or their family, the reasons should be informed by legal advice and recorded.

3.3 Responsibilities to staff

The staff directly involved in the care and support of individuals subject to a SAR should be notified, by the agency they are employed by, of the decision to undertake the SAR and support should be provided to them. The process and their involvement should be fully explained and for those unfamiliar with the process, they should be signposted to guidance as required.

At the end of the process, HSAB should consider whether staff should be invited to a feedback session, involving representation from the agency/agencies concerned.

Particularly with the systems and methodologies it is key that all agencies ensure there is internal support for those involved. This methodology is highly reflective, very interactive and while the benefits of collaborative analysis is positive, staff can feel challenged by this approach.

3.4 Reporting arrangements

The SAR Panel will provide regular updates to HSAB on the progress of the review. The SAR should be completed within six months of the review being established. Once completed, the report and recommendations will be presented to the HSAB for consideration.

Once the report is approved, the SAR Panel will produce a multi-agency action plan responding to any recommendations made. Monitoring of the implementation of this action plan will be undertaken by HSAB. The norm will be to publish an anonymised version of the full report Halton Borough Council Safeguarding Adults webpage and the Halton Safeguarding Adults Board Portal. However, in exceptional circumstances and only with agreement of HSAB, this practice may vary.

All SARs conducted within the year must be referenced within HSAB's Annual Report, together with relevant service improvements planned, with timescales and achievements. HSAB must include the findings from any SARs in its Annual Report and what actions it has taken, or intends to take in relation to those findings. Where HSAB decides not to implement an action then it **must** state the reason for that decision in the Annual Report.

SAR reports should:

- Provide a sound analysis of what has happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Be written in plain English;
- Contain findings and recommendations of practical value to organisations and professionals;
- Be suitable for publication (if agreed by the family);

- Be translated into a SMART action plan that can be effectively monitored with clear outcomes.

3.5 Complaints

The Local Government Ombudsman (LGO) has jurisdiction to investigate complaints about safeguarding investigations for which Councils have co-ordinating responsibility. Although safeguarding investigations are multi-agency in nature this does not preclude the Local Government Ombudsman from investigating matters that relate to the actions of professionals employed by organisations that do not fall within the Local Government Ombudsman jurisdiction.

Depending on the nature of the complaint, the current LGO practice when receiving a complaint is to consider whether:

- The safeguarding investigation is proportionate;
- The Council has taken appropriate action in response to the findings of the safeguarding investigation;
- The Council continues to monitor the situation;
- The Council can provide evidence why the safeguarding allegations did not meet the safeguarding threshold;
- There were any delays or other failures in the process;
- Whether the conclusions are consistent with the evidence;
- The Council considered all relevant and available evidence.

3.6 Information sharing

3.6.1 Record Keeping

Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.

Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:

- What information do staff need to know in order to provide a high quality response to the adult concerned?
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm?
- What information is not necessary?

- What is the basis for any decision to share (or not) information with a third party?

Records should be kept in such a way that the information can easily be collated for local use and national data collections.

All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know.

In order to carry out its functions, SABs will need access to information that a wide number of people or other organisations may hold. Some of these may be SAB members, such as the NHS and the Police. Others will not be, such as private health and care providers or housing/support providers or education providers.

In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what 'went wrong' and so has hindered them identifying, to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening they must act upon that knowledge; not wait to be asked for information.

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; or
    - The information requested has already been supplied to another person subject to a SAB request for information.

3.6.2 Confidentiality

Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review published in 2013:

- Information will only be shared on a 'need to know' basis when it is in the interests of the adult;
- Confidentiality must not be confused with secrecy;

- Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement;
- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian and/or Data Protection Officer should be involved.

Decisions about who needs to know and what needs to be known should be taken on case by case basis, within agency policies and the constraints of the legal framework.

Principles of confidentiality designed to safeguard and promote the interests of any adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) where applicable.

Information in a range of media should be produced in different user-friendly formats for people with care and support needs and their carers. These should explain clearly what abuse is and also how to express a concern to make a complaint. Adults with care and support needs and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

If an adult has no appropriate person to support them and has substantial difficulty in being involved in the local authority processes, they must be informed of their right to an independent advocate. Where appropriate, local authorities should provide information in access to appropriate services such as how to obtain legal advice or counselling services, for example. The involvement of adults at risk in developing such communication is sensible.

Table of separate appendices

A range of documents are included as separate, embedded files in the table below. They can be opened and saved separate to this main policy document. For example, to make a referral; open the referral form below, save as, complete sections as appropriate, save and return as indicated on the form.

Appendix number/name:	Document purpose:	Embedded file:
1. SAR Referral Form	Any agency or individual can refer a case for consideration by the Halton Safeguarding Adults Board. This form can be used to refer a case that may meet the criteria for a Safeguarding Adult Review or a case where there are significant and unresolved concerns and the decision making framework for a SAR may be appropriate.	 Appendix 1 - SAR Referral Form.docx
2. SAR Decision Process Flow Chart	Flow chart depicting the processes for determining whether or not a SAR should take place.	 Appendix 2 - SAR Decision Process Flo
3. SAR Methodologies	Provides further information on a range of different SAR methodologies.	 Appendix 3 - SAR Methodologies.doc
4. Example Terms of Reference for a SAR Panel	Example / template Terms of Reference that can be used for SAR Panels.	 Appendix 4 - Example SAR Panel T
5. Chronology Template	Table for recording a chronology of significant events during the time period under review.	 Appendix 5 - SAR Chronology Templat
6. Overview of the SAR Process	Summarises the key elements of the SAR process.	 Appendix 6 - Overview of the SAR
7. SAR Guidance for Families	A brief question sheet to provide information and guidance to families regarding SARs.	 Appendix 7 - SAR Guidance for Famili