The Essential Guide

to

Safeguarding Adults Reviews (SAR)



National Network for Chairs
of Adult Safeguarding Boards

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Foreword

This Essential Guide has been developed to offer a clear, practical reference point for Safeguarding Adults Boards (SABs) as they navigate the Safeguarding Adults Review (SAR) process. It is not intended to be read sequentially, but to act as a resource that Boards can dip into at any stage of commissioning, managing, or learning from a SAR.

While the Care Act 2014 and the accompanying statutory guidance outline the legal responsibilities for undertaking SARs, they intentionally avoid prescribing a specific process. This includes only one defined timeframe — the expectation that a SAR should normally be completed within six months. All other timescales referenced in this Guide are therefore not statutory requirements but reflect recognised best practice to support timely, proportionate and well-governed decision-making.

This flexibility brings important advantages: it enables each SAB to design approaches that reflect their local community, governance structures, and ways of working. However, it also means that SAR practice, terminology, and oversight arrangements vary significantly from area to area.

This Guide embraces that variation. It uses broad, inclusive and commonly understood language, while recognising that local interpretation is not only expected but essential.

Above all, the Guide aims to promote clarity, shared principles, and consistent expectations — without constraining local autonomy. It provides practical support to strengthen SAR processes, enhance quality, and promote learning that leads to meaningful improvements for adults at risk of, or experiencing, abuse or neglect.

Acknowledgement

We extend our sincere gratitude to everyone who contributed to the development of this guidance. This includes the members of the **Expert Reference Group**, the **National Networks**, and colleagues from **Local Safeguarding Adults Boards** across the country. Your expertise, commitment, and collaborative spirit have been invaluable.

This work is a testament to the power of partnership and shared dedication to improving safeguarding practice for adults everywhere.

We would also like to extend our **sincere thanks to the individuals with lived experience, and to their families**, who so openly and generously shared their experiences, reflections, and thoughts with us.

We want to acknowledge and recognise the courage required to revisit such difficult memories, and we are sincerely grateful for the time, openness, and trust placed in us.

The insight offered, even when rooted in painful experiences, has been invaluable in helping us understand what matters most—what works well, what can be strengthened, and what the SAR process truly feels like. Their willingness to take part in interviews and share their experiences has brought authenticity, depth, and humanity to this guidance.

The voices of those with lived experience have shaped not only the content but also the purpose of this work, ensuring it remains grounded respecting the real challenges, and real opportunities for learning and improvement in current practice. The direct quotations included throughout this guidance come from the adults and families who contributed, and we remain genuinely thankful for your honesty, generosity, and commitment to helping create safer, more compassionate systems for others.

Contents Page

Foreword 1

Acknowledgement 1

1. Introduction 5

2. National Workstreams Aligned to the Essential Guide to SARs 6

3. What is a Safeguarding Adults Review (also known as a SAR)? 7

4. Purpose of a Safeguarding Adults Review (SAR) 9

5. Embedding MSP and the Six Principles in SARs 10

5.1 Making Safeguarding Personal 10

5.2 The Role of the Six Safeguarding Principles 11

6. What SARs 'can' and 'cannot' do 12

6.1 What SARs Can Do 12

6.2 What SARs Cannot Do 12

7. Information Sharing and Multi-Agency Cooperation 13

7.1 Legal Framework of Sharing Information 13

7.2 Key Principles for Cooperation and Information Sharing in SARs 14

8. Use of Artificial Intelligence (AI) in SAR Commissioning and Report Writing 14

9. Decision-Making Standards from Administrative Law 15

10. Importance of person-centred, strength-based language 16

10.1 What is 'person-first' language? 16

11. Voice of the Adult and including Involving Families and Carers in SARs 17

11.1 Engaging Non-Engaging Families 18

11.2 Working With Litigating or Legally-Represented Families 19
11.3 Use of Names within SARs 19
11.4 Best Practice 20
11.5 Top Tips for Meaningful Engagement 21
12. Balancing Meaningful Involvement with Managing Complex Dynamics 22
12.1 Effective Engagement 22
13. Role of Advocacy 26
14. Role and Responsibilities of the SAB and partners 26
14.1 SAB Independent Chair 26
14.2 Role of the SAB Board Manager 27
14.3 SAR Subgroup Panel Members 29
14.4 Statutory and Wider Partners 30
14.5 Independent Reviewers 30
14.6 Members of the SAR Review Panel/Group 32
15. The Safeguarding Adult Review (SAR) Process 33
15.1 SAR Referral 33
15.2 What a Good-Quality SAR Referral Looks Like 34
15.3 Screening of SAR Referral: National Context and Best Practice 37
15.4 SAR Decision Making Flowchart 39
15.5 Outcome of the decision making process 41
15.6 SAR Timelines and Promoting Timely, Defensible Reviews 41
15.7 Commissioning Arrangements for SARs 42
15.8 SAR Review Panel/Group 45
15.9 Chairing the SAR Review Panel/Group: Eligibility and Responsibilities 46
15.10 Membership of the SAR Panel/Review Group 46
15.11 Terms of Reference for a SAR 47
15.12 When the Adult's or Family's Voice Diverges from the SAR Terms of Reference 51
16. SAR Methodologies 52
16.1 Methodological Flexibility and Good Practice 52
16.2 What are SAR Methodologies? 52
16.3 Methodology When the Adult Is Alive 55

16.4 Choosing the Right Methodology 56
17. Voice of Frontline Practitioners, Managers and Senior Leaders in SARs 61
17.1 The Critical Role of the Frontline Practitioners 62
17.2 Why Practitioner Involvement Strengthens Learning 62
17.3 Looking Forward: Learning from Current Practice 62
18. Managing Disagreement and Escalation 62
19. Quality of SAR reports 64
20. Questions versus Recommendations? 65
20.1 Recommendations 66
20.2 Questions 67
21. Policy, Practice and Learning: Evidence-informed SARs 69
22. Actions and Action Plans 72
22.1 Top Tips for Sharing, Tracking and Embedding Learning from SARs 73
23. Governance Overview: Acceptance and sign off of a SAR 76
24. Why SARs Are Expected to Be Published on the Local SAB's website and Why It Matters 79
24.1 When to publish a SAR 80
24.2 When NOT to publish a SAR 81
24.3 Publication When the Adult Is Still Alive 83
24.4 Publication of SARs and Managing Coroner's Inquests 85
25. Organisational Memory in SARs – why this matters? 86
26. Learning Events 91
26.1 Key Components of Effective Learning Events 92
27. Impact and Outcome of SARs – Achieving and Evidencing Systemic Change 94
28. Legal Support and Advice 96
29. Media and Comms (including social media) 97
30. Complaints and Compliments from Members of the public 98
31. Other Statutory and Non Statutory Reviews 102
31.1 Domestic Abuse Related Deaths Reviews (DARDR) 102
31.2 Child Safeguarding Practice Review (CSPR) 103
31.3 Learning from Lives and Deaths (LeDeR) 104
31.4 Patient Safety Incident Response Framework (PSIRF) 105

31.5 Drug-Related Death (DRD) Reviews and Panels 106
32. Joint Statutory Reviews Across Adults, Children and Domestic Abuse 107
32.1 Governance and Oversight 110
32.2 Examples of Joint SAR/DARDR 115
32.3 Examples of Joint SAR/CSPR 116
33. Other Parallel Processes 116
34. Managing SARs Across Local Authority Boundaries 118
35. Shared Funding of Statutory Reviews (Cross Border or Joint Reviews) 121
36. Care Leavers and Duty of Notification 122
37. The role of Care Quality Commission (CQC) in SARs 123
38. Local SAB's Responsibilities in Reporting SARs 124
39. National Library of SARs 125
40. Conclusion 126

1. Introduction

This Essential Guide is an interactive, practical reference document designed to support Safeguarding Adults Boards (SABs), Independent Chairs, Independent Reviewers and SAB Business Managers in developing and maintaining a robust process for managing Safeguarding Adults Reviews (SARs). It is intended as a **guide for local areas to draw upon**, offering considerations, principles and good practice examples rather than prescribing a single model that must be implemented.

Throughout the Guide, reference is made to legislation, statutory guidance and legal duties—such as those contained within the Care Act 2014 and the Care and Support Statutory Guidance—to ensure clarity about what is required within the legal framework. However, **how** SABs apply this information will necessarily be shaped by local context, structures and protocols.

Importantly, this document does **not** replace or override the established SAR Protocols of individual SABs. Each SAB retains its statutory responsibility to determine whether SAR criteria are met, to commission reviews, and to apply its own local procedures.

Instead, this Guide sits alongside local protocols and aims to:

- Provide a shared regional framework that complements local arrangements
- Support partners and reviewers who work across multiple SAB areas
- Promote proportionality, transparency, and high-quality practice

- Strengthen cross-boundary coordination where joint reviews are required
- Encourage reflective, person-centred, and evidence-informed practice

The Guide has been structured to be accessible and easy to navigate. Many elements of the SAR process are cross-cutting; therefore, some themes appear in more than one section. This is intentional. Each section is written to stand alone, enabling readers to access relevant information without needing to return to earlier chapters, while still offering a coherent and connected narrative.

This document includes:

- An **interactive contents page** enabling direct navigation to areas of interest
- External links to legislation, statutory guidance, national research and sector resources such as the SCIE SAR Quality Markers
- Practical tools, reflective questions and decision-making prompts
- Embedded best-practice principles aligned with the Care Act 2014, Data Protection Act 2018 and national standards
- Practice examples and links to SAB templates
- Direct quotes from adults and families with lived experience, ensuring their voices remain central throughout

References to the SCIE Safeguarding Adults Review Quality Markers are included throughout to promote proportionate, transparent and consistent SAR practice in line with nationally recognised standards.

This Guide is a working resource and will be reviewed and updated to reflect evolving legislation, policy developments and learning from SARs across England.

For ease of reference, Safeguarding Adults Boards are referred to as **SABs**, and Safeguarding Adults Reviews are referred to as **SARs** throughout.

2. National Workstreams Aligned to the Essential Guide to SARs

Alongside the development of this Essential Guide, a series of national workstreams have been undertaken through the National Chairs Network to strengthen consistency, transparency and impact in SARs practice across England. These workstreams complement the purpose and design of the Guide by offering a broader national perspective on what supports effective SAR commissioning, analysis and learning.

The outcomes of each workstream will be published on the National Chairs Network webpages (the link has been provided below)

Workstream 1 – SARs: Five Domains of Good Practice

This workstream explores five core domains of effective SAR practice and sets out clear, practical guidance on what "good" looks like. The guidance produced in Workstream 1 directly enhances the sections of this Guide focused on quality, transparency and proportionality, ensuring alignment with national expectations.

Workstream 3 – From Learning to Impact

This workstream focuses on the crucial challenge of moving beyond lessons identified to demonstrating meaningful change and measurable impact. It provides:

- Methodologies for evidencing improvements in policy, practice and organisational culture
- Tools to support SABs in tracking change over time
- Approaches for linking SAR findings to strategic priorities, multi-agency audit and assurance processes

This workstream strengthens the emphasis within this Guide on reflective, evidence-informed practice and supports SABs to build a clear line of sight between learning, action and improved safeguarding outcomes.

Workstream 4 – Care Act 2014: Ten Years On

Marking a decade since implementation of the Care Act 2014, this workstream examines:

- What is working well in adult safeguarding under the existing legal framework
- Persistent gaps in law, policy and operational practice
- Areas where additional clarity or reform may be beneficial

The analysis informs sections of this Guide that reference statutory duties, proportionality, governance and the application of the Care Act in SAR decision-making. It also supports SABs in understanding the wider national context that shapes local SAR activity.

The outcome of each of these workstreams will be published on the National Network Chair Website under 'Resources' which can be found here.

3. What is a Safeguarding Adults Review (also known as a SAR)?

A Safeguarding Adults Review (SAR) is a statutory, learning-focused review carried out when an adult with care and support needs dies or experiences serious harm, abuse or neglect is known or suspected and there are concerns how partners worked together to safeguard the adult.

Its purpose is to understand what happened, identify learning for agencies, and improve safeguarding practice across the system—not to apportion blame.

A SAR sits under the legal framework of the **Care Act 2014** (England), specifically, Section 44 places a statutory duty on local SABs to commission a SAR when certain criteria are met.

Supporting guidance is set out in the Care and Support Statutory Guidance, Chapter 14, from Paragraph 14.162, which explains how SARs should be conducted, their purpose, and expectations for multi-agency learning.

SABs **must** (mandatory) arrange a SAR when: Care Act 2014

Care Act 2014 S44, (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

S44 (2) Condition 1 is met if -

(a)the adult has died, and

(b)the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

S44 (3) Condition 2 is met if -

(a)the adult is still alive, and

(b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the **Mandatory Duty** referenced above, there is also a **Discretionary Duty** which is when:

- SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. (Care Act 2014, S44 (4)).

The adult **does not need to have been in receipt of commissioned care and support services** for the SAB to arrange a SAR.

Its important to understand that when mandatory and discretionary duty is applied, both are therefore **statutory reviews**. There is **no such thing as a 'non-statutory review'.**

Please note - Section 44 of the Care Act 2014 does not apply to adults who are living in prisons or approved premises, as safeguarding enquiries and Safeguarding Adults

Reviews (SARs) for these individuals fall outside SAB jurisdiction and are the responsibility of the custodial institution. (Care Act 2014, section 76)

For further information – the relevant sections for SARs are referenced in the Care Act section 44 and Care and Support Statutory Guidance, paragraphs 14.162 to 14.173.

4. Purpose of a Safeguarding Adults Review (SAR)

[SCIE Quality Marker 4: Clarity of Purpose]

The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. SARs may also be used to explore examples of good practice (Care and Support Statutory Guidance, Paragraph 14.164).

It is vital that individuals and organisations learn lessons from the past and that the review process is trusted. It should be a safe experience for everyone involved, one which encourages honesty, candour, transparency and sharing of information to obtain maximum opportunity to identify areas of learning or good practice. If individuals or their organisations are fearful of SARs, their response will be defensive, and their participation guarded and partial.

Its purpose is **not to hold any individual or organisation to account**. Other processes exist for that. (Care and Support Statutory Guidance, paragraph 14.168)

It is about learning lessons and improvement.

The Care and Support Statutory Guidance, paragraph 14.167 states that the following principles should be applied by SABs and their partner organisations to all reviews:

- 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 a serious nature should be led by individuals who are independent of the adult central to the 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.

- Adults 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.

SARs as a statutory duty have now been embedded for over a decade, which has enabled the development of a substantial National SAR Library of learning across England. This accumulated knowledge provides a rich evidence base of recurring themes, systemic challenges, and examples of good practice. Therefore, as highlighted in the Second National Analysis of Safeguarding Adults Reviews (SARs), there is now a greater emphasis on building on existing learning rather than starting from scratch.

This approach brings together existing insights, highlights recurring patterns, and reinforces the implementation of previous recommendations to support meaningful and sustained improvement. It reflects a shift from reactive learning to proactive development—ensuring that lessons are not only identified but embedded into enduring practice, policy, and wider system change. Importantly, it also strengthens the importance and **impact** of reviews by supporting consistent changes in frontline practice, improving inter-agency collaboration, and enhancing how the safeguarding system functions operationally.

[The National SAR Library on the National SAB Chairs website is a repository for published SARs. It does have a search facility that will be updated to improve its functionality. Some of the data regarding the SARs used for the 2 national analyses is hosted by Research in Practice and can be accessed through them]

5. Embedding MSP and the Six Principles in SARs

Making Safeguarding Personal (MSP) and the six safeguarding principles provide an essential ethical and practical framework for how SARs should be approached, conducted, and used for learning. While the SAR process must maintain independence and objectivity, it should also remain grounded in the values that underpin all adult safeguarding activity.

5.1 Making Safeguarding Personal

MSP reinforces that safeguarding is fundamentally about supporting adults to achieve the outcomes that matter to them. Within a SAR, this means:

- Keeping the lived experience, wishes, feelings and values of the adult at the centre of the analysis.
- Considering not only “what happened” but also whether the person was heard, respected, and meaningfully involved in decisions about their life.
- Reflecting on how agencies sought (or failed) to understand what mattered most to the adult, and how this shaped the safeguarding response.

- The family, carers (both formal and informal), and those closest to the adult should have the opportunity to contribute to the review, recognising that they are often the people who know the adult best and can offer unique insight into their history, wishes, experiences, and the support they received. Their involvement should be facilitated sensitively, appropriately, and in line with their preferences and wishes.

> "Agency records were poor so there was little for the reviewer to look at. They did not interview all relevant staff. They did not pick up our suggestions to interview other staff members – they did not look at the context"
>
> (Family Member)

By anchoring the SAR in MSP principles, the learning extends beyond procedural compliance and instead highlights what good, person-centred practice should look and feel like.

5.2 The Role of the Six Safeguarding Principles

The six safeguarding principles — empowerment, prevention, proportionality, protection, partnership, and accountability — offer a lens through which to understand both the practice seen in the review and the system factors behind it. In the SAR process, these principles help to:

- **Guide analysis**
  Reviewing agencies' actions in relation to the principles supports balanced, reflective learning. For example, asking whether practice empowered the adult, whether risks could have been prevented earlier, or whether agencies worked in partnership effectively.
- **Identify gaps and strengths**
  Mapping themes against the principles can highlight where systems are working well and where structural barriers undermine good practice.
- **Promote consistency in learning**
  Using the principles as a thread through findings helps ensure the review remains rooted in nationally recognised expectations of good safeguarding practice.
- **Support meaningful recommendations**
  Recommendations grounded in the safeguarding principles tend to be more outcomes-focused, realistic, and aligned with wider statutory responsibilities.

The Golden Thread

Both MSP and the safeguarding principles should act as a "golden thread" throughout the SAR — not only referenced in individual findings, but shaping the tone, methodology and conclusions of the review. They help keep the focus on the adult, ensure learning is values-based as well as procedural, and support a culture where safeguarding responses promote dignity, voice, and safety.

6. What SARs 'can' and 'cannot' do

6.1 What SARs Can Do

- **Identify learning**: Highlight shortcomings, what went well, and how practice and services can improve.
- **Support accountability**: Encourage transparency and reflection without assigning blame.
- **Amplify the voice of the adult and their families**: Ensure the adult's experience and those of their families are heard and respected throughout the process.
- **Improve safeguarding practice**: Strengthen safeguarding practice through improved prevention, earlier identification of concerns, and timely responses to potential harm or neglect.
- **Improving social and health provision**: to reduce the opportunity for harm and neglect to occur. Strengthen prevention and response to future harm or neglect.
- **Support multi-agency learning**: Promote shared responsibility and collaboration across services.
- **Promote system change:** Recommend improvements to policies, procedures, inter-agency working, and the commissioning and delivery of services. This includes identifying where commissioning arrangements or service models contribute to gaps or inconsistencies, and highlighting opportunities to strengthen service quality and alignment with local need. In doing so, SARs help drive sustainable, whole-system improvement.

> "We just want the learning to be shared, so no other family have to go through what we have gone through"
>
> (Family member)

6.2 What SARs Cannot Do

- **Apportion blame**: SARs are not disciplinary or legal investigations.
- **Determine criminal or civil liability**: They do not replace police, coroner, or court processes.
- **Reinvestigate**: SARs do not re-investigate the safeguarding concerns or determine liability, but may draw on additional insights from practitioners, families or learning events to understand how information was interpreted and acted upon at the time.

- **Act as a complaints process**: They are not a substitute for formal complaints or appeals.

- **Guarantee implementation**: While they make recommendations, SARs cannot enforce change.

While SARs cannot change what has happened to the adult, they can honour the individual by ensuring that their experience leads to meaningful learning and support and encourage systemic change both locally and nationally.

7. Information Sharing and Multi-Agency Cooperation

Information sharing and multi-agency cooperation is vital in SARs because they ensure a comprehensive understanding of the adult's situation, enabling a collaborative and holistic approach to identify patterns of abuse, prevent future harm, and improve safeguarding practice.

7.1 Legal Framework of Sharing Information

The legal framework for sharing information in adult safeguarding, including SARs, is underpinned by the **Care Act 2014**, which emphasises the importance of timely and proportionate information exchange between agencies to prevent harm, alongside compliance with the Data Protection Act 2018, General Data Protection Regulation (GDPR) Policy UK, the Human Rights Act 1998, and the common law duty of confidentiality.

The **Care Act 2014** includes:

- **Section 44**: The mandate for SABs to commission SARs.
- **Section 6 & 7**: The duty on local authorities and relevant partners (for example, NHS, police, housing) to **cooperate** in safeguarding matters.
- **Section 45**: Empowers SABs to request information from any person or body if it is needed for a SAR (or the completion of other SAB statutory duties). The person must comply if they are or have been involved in the adult's care or support and have the information that has been requested.
- Care and Support Statutory Guidance, paragraph 14.186 – 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 it's 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 an SAB request for information

UK GDPR & Data Protection Act 2018

- **Lawful basis for sharing**: SARs can rely on the lawful bases of **public task**, **legal obligation**, or **vital interests**.
- **Data minimisation and proportionality**: Only share what is necessary and relevant.
- **Transparency**: Inform individuals where appropriate, unless doing so would compromise the review or increase risk.
- **Security**: Ensure data is shared securely and only with those who need to know.

UK GDPR applies only to information relating to living individuals; data about adults who have died is not covered by UK GDPR, although confidentiality, ethical duties, and relevant organisational policies must still be upheld

7.2 Key Principles for Cooperation and Information Sharing in SARs

1. **Timeliness**: Delays in sharing information can hinder learning and risk management.
2. **Clarity of purpose**: Agencies must understand why information is needed and how it will be used.
3. **Protocols and agreements**: SABs should have clear protocols for information sharing during SARs.
4. **Respect for confidentiality**: While confidentiality is important, it should not override the need to safeguard adults at risk.
5. **Learning culture**: Agencies should approach SARs with openness and a commitment to improvement, not defensiveness.

8. Use of Artificial Intelligence (AI) in SAR Commissioning and Report Writing

The integration of Artificial Intelligence (AI) tools, such as Copilot, into SAR processes is an emerging area of practice. AI offers significant potential benefits, including enhanced efficiency, improved clarity, and support for reflective analysis. For example, AI can assist in summarising large volumes of electronic notes, maintaining consistent language, and identifying recurring themes across multi-agency contributions. It can also help link findings to relevant legislation and produce accessible summaries for wider dissemination.

However, the use of AI also presents challenges and risks that must be carefully managed and used with caution.

Key considerations include:

- **Data Privacy and GDPR Compliance**: Inputting sensitive personal data into AI systems might breach UK GDPR and data protection laws. All data must be anonymised or explicitly authorised, and AI should only be used within secure, SAB-approved environments.
- **Accuracy and Reliability**: AI-generated outputs might contain errors or misinterpret context. SARs require precise, evidence-based analysis; therefore, all AI outputs must be verified against source documents.
- **Ethical and Legal Accountability**: Over-reliance on AI could undermine statutory duties under the Care Act. Human judgement, empathy, and contextual understanding remain essential.
- **Bias and Transparency**: AI models might reflect biases in training data, and their decision-making processes or the narrative and context that oftens sits behind data are not always transparent. SARs must remain impartial and defensible.

Commissioning Principle: The decision to use AI must be agreed at the point of commissioning the SAR. There should be a clear, documented agreement outlining:

- When AI tools can be used (e.g., for summarising or formatting) and when they must not (e.g., core analysis or decision-making).
- How outputs will be verified and integrated into the final report.
- Compliance measures for GDPR, confidentiality, and ethical standards.

Including a methodology section in SAR reports that explains how AI was used can support transparency and accountability. **Ultimately, AI should be viewed as a supportive tool—not a substitute for professional expertise and judgment.**

Please remember – the above information has been provided based on what is known at the time of writing. AI technologies are continually developing, and the ways in which AI is used will continue to evolve over time. Readers should therefore consider this content as guidance rather than definitive, and apply professional judgement when interpreting or acting upon it.

9. Decision-Making Standards from Administrative Law

Local SAB decisions about SARs, including whether or not to commission and publish, and who to involve, can be the focus of an application for judicial review or complaint to the Local Government and Social Care Ombudsman. For defensible decision-making,

SABs should ensure compliance with standards from administrative law, namely that decisions are:

1. Lawful, reasonable and rational.
2. Timely, meaning the avoidance of negative delay.
3. Taken after the involvement of those who have a reasonable expectation to be consulted, where safe to do so.
4. Procedurally fair.
5. Free from bias and taken after due regard to all relevant considerations.
6. Supported by recorded reasons, with a right of review.

10. Importance of person-centred, strength-based language

10.1 What is 'person-first' language?

Person-first language is a way of speaking or writing that aims to reduce the stigma associated with disability by focusing on the **individual first**. It avoids using labels that define a person solely by their disability.

Person-first language prioritises the individual by placing the word "person" or "people" before any mention of their disability or condition.

With person-first language, we want to try and remove the use of language like 'service user' and 'cases'.

Examples being:

- **Instead of:** "Learning Disable Person", **Use:** "Person with a Learning Disability "
- **Instead of:** "The blind woman", **Use:** "The woman who is blind."
- **Instead of:** "A wheelchair-bound user", **Use:** "A person who uses a wheelchair."

Why is it important?

- **Respect and Dignity:** Person-first language promotes respect and dignity for individuals with disabilities by recognising their inherent value as people.
- **Reduces Stigma:** It helps to dismantle negative stereotypes and stigmas associated with disability.
- **Focus on the Individual:** It emphasises that a person's disability is just one part of their identity, not the defining characteristic.
- **Promotes Inclusion:** It can contribute to a more inclusive and welcoming environment for people with disabilities.

As part of a person-centred approach, the SAB and the reviewer should ask the adult (or their representative, where appropriate) how they would like to be referred to

throughout the SAR, recognising the importance of language, dignity and personal preference for all individuals.

11. Voice of the Adult and including Involving Families and Carers in SARs

[SCIE, Quality Marker 3: Informing the person, members of their family and social network] and [SCIE, Quality Marker 11: Involvement of the person, relevant family members and network]

SARs may be undertaken whether the adult is alive or has sadly passed away. In all circumstances, it is essential that their voice is heard and that their experiences, wishes, and perspectives remain central to the review, this may include speaking to the adult, their carers, family or other significant person involved with the adult. Their involvement should shape learning and drive improvements in practice.

Every effort should be made to involve the adult, and where appropriate their family or any member of their wider social network, throughout the process. However, it is recognised that there may be exceptional circumstances where this may not possible — for example, when contact cannot be established or there is no response to communication.

Where it is deemed not appropriate to make contact, a clear and defensible rationale must be documented.

All attempts and communications should be recorded as evidence that every reasonable effort has been made.

Where the adult is living, or where children are involved, the implications of limited or no contact may affect what can be shared when the review is published, and this should be carefully considered throughout the review process.

Early and proactive engagement is important. It would be seen as best practice, when considered to be appropriate to do so for the SAB to make contact with the adult, their family, and representatives at the earliest opportunity in the SAR process so that the adult and/or families' perspective can be taken into account.

These early conversations will enable the local SAB to explained the purpose and process, whilst obtaining their initial views on how they feel partners worked together which can then be fed into the decision making process.

'You can get lost in the process. I wanted to be part of every single step of the process. To know how it works. I was helped as to how the process works.'

(Adult with Lived Experience)

The adult, their families and carers (paid and unpaid) bring unique insights into the adult's life, needs, and experiences. Their perspective often differs from that of professionals and is essential for shaping coordinated and compassionate responses. Their involvement should begin early and continue throughout the review.

The SAB should maintain ongoing communication to:

- Confirm whether SAR criteria have been met.
- Provide regular updates, ensuring transparency and clarity.
- Discuss early how the adult and/or their representatives may wish to be involved in the review, should they choose to participate (Care and Support Statutory Guidance 14.165).

All contact with adults and families should be made with empathy and sensitivity. Practitioners should take account of significant dates (such as birthdays, anniversaries of the adult's death, or upcoming processes such as a coroner's inquest) and ensure that communication is trauma-informed. Using plain English and avoiding professional jargon helps individuals understand and feel fully included. Information must also be accessible and provided in formats that meet individual needs.

> "Approach the individual as naturally as possible. Sit down with them, have an initial face to face meeting. Gradually I felt relaxed"
>
> (Adult with Lived Experience)

11.1 Engaging Non-Engaging Families

Families may disengage from the SAR process for many reasons, including trauma, mistrust, previous negative experiences with services, or competing life pressures. SABs should demonstrate that **meaningful attempts were made to involve the family**, even where engagement is limited. Best practice includes:

- Using a **trauma-informed, flexible approach** to contact (e.g., offering written, virtual or face-to-face options).
- Allowing families to engage **at any stage**, not only at the beginning.
- Ensuring communication is **clear, jargon-free, and paced** appropriately.
- Respecting that non-engagement is a valid choice; the SAR should still reflect the adult's and family's voice using available records and information.
- Recording all contact attempts transparently, including methods used and the responses received.

A lack of involvement from families should **never prevent** a SAR from being carried out or weaken its learning.

11.2 Working With Litigating or Legally-Represented Families

Some families may be pursuing legal action, raising complaints, or involving solicitors while a SAR is underway. This does not prevent the SAB from conducting a review, but SABs must handle the situation carefully by:

- Clarifying that a SAR is **not a legal process**, nor does it apportion blame.
- Offering written information about the **separate purpose and scope** of SARs compared to legal proceedings.
- Ensuring **consistent, transparent communication** that avoids prejudicing legal processes.
- Liaising where appropriate with local authority or organisational **legal services** for advice on correspondence and disclosure.
- Keeping boundaries clear — the SAB's role is learning-focused, not to resolve disputes or respond to allegations of liability.

Where families have legal representatives, SABs should communicate through them where requested, while still offering the family opportunities to contribute directly if they wish.

11.3 Use of Names within SARs

The Independent Reviewer and SAB should offer the family (and, where appropriate, those who knew the adult well) about how the adult will be referred to within the SAR. Families may prefer the adult's given name to be used (subject to legal considerations) or a pseudonym to maintain anonymity and protect privacy..

To ensure this is an informed decision, the family must understand how the report will be used, where it may be published, and the potential audience for the learning. This discussion should take place sensitively at the earliest opportunity, and the family's preference must be clearly recorded and used consistently throughout the SAR and associated publications.

- **Respect & Dignity:** Treat all individuals with compassion, fairness, and sensitivity.
- **Person-Centred Care:** Ensure decisions reflect the adult's wishes, feelings, and lived experience.
- **Transparency & Inclusion:** Maintain open, regular communication throughout the process.
- **Trauma-Informed Practice:** Recognise trauma, avoid re-traumatisation, and communicate gently and respectfully.

"We were consulted on what name to use for our mother and we agreed to initials. The reviewer wanted the report to be impactful. We wanted publication. We understood that the report would be used by SABs and different groups"

(Family Member)

"For me there was no warm handover, no warm contact… it was very process driven. This is the tick box."

(Family Member)

11.4 Best Practice

Early & Ongoing Communication

- Make contact at the earliest opportunity — ideally at referral or screening stage.
- Follow verbal communication with written information (letter or leaflet).
- Explain the SAR process clearly and repeat explanations where needed.
- Provide a named contact for updates and questions.
- Offer regular progress updates and clarify how the individual's contributions will influence the review.
- Begin discussions early about the adult's preferred name for use in the SAR (given name or pseudonym).

Emotional & Practical Support

- Signpost or refer individuals to:
  - Bereavement support (local or national)
  - Advocacy services for the adult at risk
  - Mental health support
- Ensure support is timely, culturally appropriate, and accessible.

Meaningful Involvement

- Ask how individuals wish to be involved (e.g., sharing their views, attending the review group, providing written statements, contributing to learning events, or reviewing findings).
- Respect decisions to decline involvement while offering flexibility to engage later.
- Capture families' experiences to inform systemic improvements.

Trauma-Informed Approach

- Recognise signs of trauma and avoid re-traumatisation.
- Use plain, everyday language and avoid jargon.
- Allow time for reflection and progress at the individual's pace.
- Consider additional support such as bereavement services, advocacy, or informal networks.

Feedback & Ending the Process

- Share SAR findings in a respectful and accessible format.
- Have the opportunity to comment on findings.
- Offer follow-up conversations to answer questions and support closure.
- Explain how learning will be used to improve practice.
- Have a conversation regarding discussion and make them aware where it will be published and how it will be used.
- Invite families to share their experience of the SAR process to inform future improvements.
- Following completion of the review, check in with the adult or family rather than bringing contact to an abrupt end.

Document & Review

- Keep a clear record of support offered and any unmet needs.
- Use this information to strengthen future SAR processes.

11.5 Top Tips for Meaningful Engagement

- **Prioritise the adult's voice:** Where direct input is not possible, draw on records and the insights of those who knew them.
- **Use creative approaches:** Visual timelines, storytelling, and advocacy can help capture lived experience.
- **Ensure accessibility:** Consider language, culture, literacy levels, cognitive ability, and avoid jargon.
- **Offer written options for contributing:** Particularly where perspectives differ from review conclusions.
- **Seek views on improvement:** Families' lived experiences often highlight gaps, strengths, and opportunities for learning that professionals might not identify.
- Recognise that bereavement, trauma, and personal circumstances may affect how much families feel able or willing to contribute. Engagement should be sensitive, realistic, and paced according to what feels safe and manageable for them.

- **"The terminology and language used was clear and easy to understand. We can change language to broaden it. Can't always use jargon if there is a member of the public involved. SARs published should have no jargon. Maybe we can do a glossary for regular SAR language"**
- (Adult with Lived Experience)

"A letter to our grandmother who did not understand what was involved and who found it difficult to manage the emotions it triggered. We had to phone the council for an explanation."

(Family Member)

12. Balancing Meaningful Involvement with Managing Complex Dynamics

Meaningful involvement with the adult and their families is a cornerstone of SARs, grounded in principles of **transparency, dignity, and respect**. It is not only best practice—it is a statutory expectation and principle under the Care Act 2014. However, involvement can present significant challenges that require **careful preparation and skilled facilitation**.

Families and individuals may experience distress, mistrust, or hostility towards what has happened and their views may differ from the perspectives of the professionals involved. There maybe some hostility against the process because they want someone or some agency to be accountable, if unmanaged, these dynamics risk undermining the purpose of the review and eroding trust.

12.1 Effective Engagement

Engagement is not simply a procedural step; it is an ethical commitment to include those most affected by safeguarding concerns. Yet, the emotional weight of these reviews—combined with systemic complexity—means everyone involved should anticipate and manage tensions proactively.

Engaging effectively with families in SARs requires sensitivity, transparency, and an appreciation of the complex emotions involved. Differences in memory, interpretation, and expectations are natural, and recognising these variations without minimising them supports more constructive dialogue.

Communicating clearly about the review process, its scope, timelines, and limitations—using plain, jargon-free language—helps reduce confusion and prevents feelings of mistrust.

Creating spaces that feel safe and inclusive is essential, whether through choosing neutral venues, avoiding hierarchical seating arrangements, or offering pre-meeting briefings to help families feel prepared and supported.

Emotional responses such as grief, frustration, or anger are to be expected, and may re-emerge throughout the process. Families often experience re-traumatisation when recounting events, and it is important to respond with empathy, patience, and, where appropriate, signpost advocacy or emotional-support services.

“You re-traumatise yourself when you talk about what happened… grief doesn’t stop on the day someone dies.”

(Family Member)

Anticipating potential disagreements enables professionals to plan for constructive resolution through mediation, facilitated discussions, or clear ground rules for respectful engagement. Where differing perspectives remain, documenting all viewpoints transparently helps demonstrate fairness, build trust, and honour the complexity of the situation.

Clear expectations about what a review can and cannot achieve, based on the agreed Terms of Reference, are central to maintaining trust. Being open about how family contributions will shape the analysis and what outcomes are realistically achievable ensures that everyone involved shares an understanding of the purpose and limitations of the review.

A trauma-informed approach should underpin all engagement, using sensitive language, pacing conversations carefully, and offering choice wherever possible to avoid unnecessary distress.

Professionals play a key role in fostering meaningful dialogue by ensuring that conversations are facilitated in a way that allows every voice to be heard. Involving an SAB representative in meetings provides continuity and reinforces the board's commitment to maintaining contact beyond the formal review process. Families often appreciate hearing how their input has contributed to learning and may value follow-up communication months or even a year after the review.

"They were really supportive… they said if I needed anything after, please get in touch. They gave me an update on the actions which was good to hear the changes that had been made"

(Family member)

Maintaining impartiality is essential for Independent Reviewers, who must avoid aligning with any single perspective. Triangulating family views with practitioner and managerial reflections and documentary evidence supports balanced, objective analysis.

Providing reflective supervision for reviewers and panel members creates space to process emotional impact, explore tensions, and maintain professional curiosity. Emphasising that the purpose of a SAR is to identify learning and improve systems—rather than apportion blame—encourages openness and reduces defensiveness.

Practical steps further strengthen engagement:

- sharing agendas and clear purpose statements in advance
- offering pre-meeting calls to reduce anxiety
- using neutral facilitation during meetings

- opening discussions with a reminder that the goal is learning and improvement
- and following up with written summaries that explain how family perspectives will inform the review.

These approaches collectively promote respectful, transparent, and supportive engagement that upholds the integrity of the review and the experiences of those most affected.

Communication with adults and families during a SAR must be sensitive, thoughtful and grounded in an understanding of the emotional impact the process may have. Families are often reliving deeply distressing or traumatic experiences, and for them this is not a 'case' or a 'process'—it is personal. Standardised, process-driven letters or impersonal updates can unintentionally add to their distress and make them feel disconnected from the review.

It is important that practitioners consciously avoid overly formal or administrative language, and instead prioritise compassionate, clear and human-centred communication. Adults and families should receive regular, timely updates even when there is little new to report, as this helps reduce uncertainty and demonstrates respect and transparency. Communication should always be tailored to the needs, preferences and circumstances of the individual or family, ensuring that they are supported to understand what is happening and why.
A compassionate, inclusive, and well-facilitated SAR process can play an important role in supporting families following serious incidents of abuse or neglect. While the purpose of a SAR is not to apportion blame, families often carry the emotional impact of what has happened, alongside unanswered questions or a need for their experiences to be acknowledged.

A positive and engaging experience can help families by:

- **Recognising and honouring the adult's life and identity**, ensuring they are seen as a person, not a case.
- **Providing clarity and understanding** about what happened, which can reduce feelings of confusion, distress, or self-blame.
- **Ensuring their voice is heard and respected**, validating their insight, experiences, and concerns.
- **Enabling meaningful involvement in shaping learning**, helping families feel that something constructive and purposeful will result from their loss or experience.
- **Supporting emotional healing**, by offering compassionate engagement, transparency, and opportunities for contribution at a pace and level that aligns with their wishes.
- **Strengthening trust and relationships** between families and agencies, particularly where confidence may have been affected.
- Boards should ensure that family engagement is thoughtful, flexible, and trauma-informed. This includes providing clear communication, offering different pathways for involvement, and ensuring support is available before, during, and after participation in the SAR or any Learning Events.

By embedding humanity, dignity, and respect throughout the SAR process, SABs can create an environment that not only promotes high-quality learning but also contributes to the family's longer-term healing and sense of legacy for the adult.

> "It was a positive experience and we had not thought it would be like that"
> (Family member)

> "The reviewer explained the process at an in-person meeting. It was very easy to communicate with him. A key is who the reviewer is. They need an awareness, an understanding, for example of trauma. They need to be compassionate, sensitive and participative. They need to have broad experience and to be able to understand our experience."
>
> (Family Member)

Positive ways of communicating include:

- Using plain, empathetic language and avoiding jargon wherever possible.
- Offering conversations in the format the adult or family prefers—phone, face-to-face, online, or written.
- Checking in regularly, rather than only contacting them at key milestones.
- Providing supportive explanations about what the SAR involves, expected timelines, and what their involvement means.
- Acknowledging the emotional weight of the process and offering appropriate signposting to support.
- Ensuring any written communication is personalised, sensitive and recognises the unique circumstances of the individual or family.

> **"Regular updates just to say what the delays are… letters are very process-driven, no humanity."**
>
> (Family Member)

By communicating with compassion and clarity, practitioners help build trust, reduce distress, and support meaningful participation throughout the SAR process.

The overarching aim is to ensure SARs are **proportionate, person-centred, and focused on learning**. While timeliness is essential, it must be balanced with the need for **quality, sensitivity, and meaningful engagement**.

13. Role of Advocacy

Under the **Care Act 2014, Section 68** local authorities have a legal duty to arrange independent advocacy from the **first point of contact** and throughout the SAR process. This support must be provided when an adult has substantial difficulty in any of the following areas:

- Understanding relevant information
- Retaining information
- Using or weighing information to make decisions
- Communicating their views, wishes, or feelings

Independent advocacy ensures the adult can participate as fully as possible in the SAR. It safeguards their rights, helps them express what matters to them, and ensures that their perspective is central to the analysis and learning. Access to advocacy is therefore not only a legal requirement but also a key mechanism for promoting transparency, dignity, and person-centred practice throughout the review.

> **"Every family should have an advocate… because if I didn't know what to ask, I probably would have sat there and asked a few questions."**
>
> (Family Member)

14. Role and Responsibilities of the SAB and partners

[SCIE, Quality Marker 7: Management of the Process]

Clear roles and responsibilities are essential to ensure a coordinated, transparent, and effective SAR. Each stakeholder plays a critical part in delivering a process that is person-centred, proportionate, and focused on learning. Defining these responsibilities helps avoid duplication, promotes accountability, and ensures that the adult's voice and family perspectives remain central throughout the review.

This section sets out the expectations for key partners, including the SAB, Independent Chair, SAR Review Group, Independent Reviewer, and contributing agencies.

14.1 SAB Independent Chair

[SCIE, Quality Marker 9: Assembling Information]

The Independent Chair plays a critical leadership role in ensuring the SAR is conducted with integrity, transparency, and a focus on learning.

Please note - references are made to Independent Chairs because this is the most common model nationally, but some SABs are chaired by statutory partners. Each SAB

should therefore interpret and apply this guidance in line with its local structures, protocols, and terminology.

Key Responsibilities:

- **Ensure the criteria of the Care Act 2014, Section 44 have been applied,** and sign off the decision regarding whether the criteria have been met.
- **Provide independent oversight** of the SAR process, ensuring it is fair, balanced, and person-centred, compliant with duties in the Care Act 2014, with standards in administrative law and with the requirements in the Care and Support Statutory Guidance.
- **Facilitate collaboration** between agencies while maintaining impartiality.
- **Ensure the adult's voice and experience** are central to the review.
- **Have oversight of the review including the development of the Terms of Reference or Key Lines of Enquiry**, ensuring clarity of scope and purpose.
- **Challenge agencies constructively** where necessary to promote accountability and learning.
- **Support the final report process**, ensuring findings are evidence-based and recommendations are actionable and disseminated.
- **Ensuring implementation and impact of review recommendations,** seeking assurance about the outcome for practice, management of practice and service development, and encouraging SAB partners to address any ongoing barriers or obstacles to best practice.

Remember – the above duties can be delegated to a member of the Board but will remain the overall responsibility of the Independent Chair.

14.2 Role of the SAB Board Manager

The Board Manager plays a critical role in ensuring that SARs are delivered effectively and in line with statutory requirements. Acting as the central point of coordination, the SAB Manager oversees the review process from initiation to completion, ensuring clear communication between the Independent Reviewer, panel members, and stakeholders. They provide governance support, manage timelines, and maintain quality assurance, helping to create a structured, transparent process that prioritises learning and improvement. By facilitating collaboration and addressing logistical and procedural challenges, the SAB Manager safeguards the integrity of the review and reinforces the Board's commitment to accountability and continuous improvement.

Overview of the SAB Managers role:

Strategic Coordination and Oversight

- Acts as the central point of coordination for all SAR activity.
- Supports the SAB Chair and SAR Subgroup in ensuring the SAR process is lawful, timely, and defensible, in line with Section 44 of the Care Act 2014.

- Ensures the SAR process aligns with Making Safeguarding Personal principles and promotes a culture of learning, not blame.

Governance and Process Management

- Oversees the SAR referral process, ensuring referrals are appropriately logged, assessed, and progressed.
- Supports the SAR Subgroup in scoping the review, drafting terms of reference, and selecting the review methodology.
- Facilitates the commissioning of independent authors and ensures contractual and logistical arrangements are in place.

Communication and Liaison

- Acts as the liaison between the SAR Panel, SAB members, and external stakeholders.
- Ensures timely and sensitive communication with:
  - Agencies involved in the review.
  - The adult (if alive) and/or their family.
  - Legal services, support local comms team to deal with the media, and any other relevant bodies
  - Be that point of contact to liaise with other parallel process (e.g., Domestic Abuse Related Deaths Reviews, Criminal Investigation or Coroners Office (unless this is delegated to Legal Departments)).
- Keeps the Independent Chair updated in the progress of the review.

"... I didn't know where the report was at points in time, Just an email or update to say, 'we haven't forgotten, this is where we're at now,' would have been useful"

(Family member)

Quality Assurance and Compliance

- Ensures the SAR process meets statutory guidance and local protocols.
- Supports the quality assurance of SAR reports and action plans.
- Maintains records of decisions, correspondence, and evidence of learning outcomes.

Learning and Improvement

- Coordinates the development and monitoring of action plans arising from SAR recommendations.
- Supports the dissemination of learning across agencies, including through briefings, training, and publications.

Administrative and Logistical Support

- Organises SAR Panel meetings, prepares agendas, and circulates papers.
- Manages timelines and ensures the SAR progresses to completion within agreed timescales.
- Supports publication and archiving of SAR reports, ensuring accessibility and transparency.

14.3 SAR Subgroup Panel Members

The Care Act and the statutory guidance do not prescribe a specific role or professional who must chair the SAR Subgroup. Instead, they set the principle that review must be objective, independent, transparent and focused on learning, and the local SAB decide the exact arrangements.

Please note - language may vary across the country to what this subgroup is called but its the meeting that makes the recommendation to the Independet Chair to whether the criteria for a SAR has been met.

The SAR Subgroup Chair should be:

- Independent of the agencies involved.
- Experienced and skilled in safeguarding and review processes.
- Able to lead the panel and ensure high quality learning.
- Ensuring legal frameworks and governance is adhered to.

There is no statutory requirement that is must be the SAB Independent Chair, a Local Authority Senior Manager, or a particular professional background – the emphasis is wholly on independence, skill and creditability.

The statutory partners (Local Authority, Police and NHS GM) share legal responsibility for consideration whether the adult meet the statutory criteria for a SAR. As core members, they must provide senior representatives with the authority to ensure that decisions are defensible, proportionate and aligned with statutory duties. Their presence at SAR screening ensures that multi-agency learning is scrutinised from health, social care and policing perspectives, and that each organisation is held to account for its role in safeguarding adults.

Members of the SAR Subgroup are responsible for reviewing referrals to make a recommendation to the Independent Chair to whether the statutory criteria for a SAR have been met. Their role is to ensure that decisions are fair, consistent, and based on a clear understanding of the Care Act 2014 requirements.

Subgroup members assess whether the adult experienced serious harm or died and whether there is concern that agencies could have worked more effectively to safeguard them. They review the quality of the referral information, request additional details where needed, and use a multi-agency lens to reach a balanced, defensible decision. Members must be impartial, declare any conflicts of interest, and not have been directly involved in the case. They ensure each referral leads to the right outcome—whether progressing to a SAR or identifying alternative learning routes such as audits or reflective reviews.

Decisions are clearly recorded, with a rationale that explains how criteria were applied and how the conclusion was reached. Screening outcomes contribute to wider SAB learning, quality assurance, and identification of emerging themes.

Final approval of the decision must be given by the Independent Chair, who signs off the outcome on behalf of the local SAB.

14.4 Statutory and Wider Partners

Statutory partners in a SAR are those agencies that have a legal duty under the Care Act 2014 to cooperate with local SABs, including the local authority, NHS organisations, and the police.

In addition, wider partners who were involved with the adult also play an important role in building a full picture of their experience and supporting systemic learning. These may include housing providers, emergency services, voluntary and community sector organisations, and commissioned care providers.

Both have core responsibilities:

- **Engage fully and openly** in the SAR process including attending the review groups, providing information and records regarding their agency involvement, participating in interviews, and attending learning events.

- **Nominate appropriate representatives to contribute to the review and ensure continuity.** Having the same representative involved throughout the process is important as it supports consistent understanding of the review, helps maintain momentum, and avoids the disruption that occurs when different people attend meetings without full background knowledge. Consistent representation also strengthens the quality of contributions, reduces repetition, and enables clearer decision-making across the review.

- **Reflect on agency practice** and contribute to identifying learning and improvement opportunities.

- **Proactive support for implementation** of recommendations within their organisation and across the partnership.

- **Promote a culture of learning** rather than blame, encouraging staff to engage constructively.

14.5 Independent Reviewers

[SCIE, Quality Marker 9: Assembling Information]

Independent Reviewers are appointed to lead the analysis and write the final report for a Safeguarding Adults Review (SAR). Their role is to provide an objective, evidence-based assessment of what happened, why it happened, and what can be learned.

As independent professionals, they ensure the review is conducted impartially, free from organisational influence, and completed within agreed timescales. Their central responsibility is to generate meaningful learning that supports improvement across agencies and strengthens safeguarding practice.

Core Responsibilities:

- **Lead the Review Process -** Plan and manage the SAR in line with the agreed Terms of Reference or Key Lines of Enquiry, ensuring it is timely, proportionate, inclusive of all relevant information and thorough.

- **Ensure the Adult's Voice is Central and is heard -** Reflect the lived experience of the adult and their family, ensuring their voices shape the learning.

- **Maintain Independence and Objectivity -** Operate without bias or influence from any agency involved in the review, ensuring credibility and trust in the findings.

- **Engage Stakeholders -** Work collaboratively with practitioners, families, and where possible, the adult at the centre of the review, to gather diverse perspectives.

- **Analyse Information and ask the 'why' question -** Review documentation, conduct interviews and learning events, and identify key themes, learning points, and systemic issues.

- **Produce a Clear, Evidence-Based Report -** Write a report that is accessible, balanced, and focused on learning and improvement, with practical and achievable recommendations or questions to the Board.

- **Support Learning and Dissemination -** Contribute to feedback sessions, learning events, or briefings to ensure findings are understood and acted upon.

Reviewer Confidence and Professional Integrity

Independent Reviewers play a pivotal role in shaping the learning and impact of SARs. It is essential that they approach their role with confidence, drawing upon their professional expertise, sector knowledge, and analytical skills.

While collaboration, openness to feedback and constructive challenge is part of the process, reviewers should feel empowered to articulate their reasoning clearly and respectfully, ensuring that the integrity of the review is upheld and that learning is not diluted by undue pressure or compromise.

Legal Support for Independent Reviewers Attending Inquests

Independent Reviewers may be asked by Coroners to provide evidence at an inquest, including jury inquests. Because reviewers are not acting as representatives of a single agency, they must be supported appropriately.

Good practice includes:

- The commissioning letter or contract specifying that the SAB will provide **access to legal advice** if the reviewer is required to attend an inquest.

- Ensuring the reviewer is briefed on:
  - the **scope of the inquest**,
  - what the Coroner has requested,
  - the distinction between the SAR process and statutory legal processes.

- SABs coordinating with partner agencies' legal teams to ensure messaging is **consistent and accurate**.

- Ensuring reviewers are **not left isolated**; the SAB should clarify who is supporting them, what documentation can be shared, and what falls outside their remit.
- Confirming that the reviewer does not provide commentary on matters outside the SAR methodology or scope.

This protects the reviewer, upholds good governance, and ensures that SAR learning remains clear, defensible, and properly contextualised.

14.6 Members of the SAR Review Panel/Group

The SAR Review Panel/Group brings together senior multi-agency representatives and subject-matter specialists to support and oversee the review process. Members must be sufficiently senior to contribute to decision making, influence organisational change, and ensure their agency remains fully engaged throughout the process.

Governance and Oversight
Members agree the Terms of Reference, scope, and methodology for the SAR and ensure the review is conducted in line with statutory duties. They provide ongoing oversight, monitor progress, and manage links with any parallel processes such as criminal investigations or inquests.

Critical Analysis and Learning
Members analyse all information submitted to the review, offering constructive challenge to identify what happened and what could have been done differently. They work with the Independent Reviewer to shape findings, support drafting of the report, and help develop meaningful recommendations to improve practice and support systemic change.

Professional Conduct and Representation
Members represent their organisation at a senior level and where possible must not have been directly involved in the adult's care. They ensure clear communication between the Review Group and their organisation, attend and prepare for all meetings, and only use deputies in exceptional circumstances. They maintain organisational oversight, including ensuring internal governance is completed before final sign-off of the SAR.

Promoting Multi-Agency Learning.
Members help identify good practice and areas for improvement, support dissemination of learning, and ensure recommendations translate into SMART[1] actions. They provide assurance that learning is embedded into practice and can demonstrate its impact.
Strategic Accountability

The Review Group provides regular updates to the Independent Chair of the SAB, ensuring strategic oversight and fulfilment of statutory responsibilities.

15. The Safeguarding Adult Review (SAR) Process

15.1 SAR Referral

[SCIE, Quality Marker 1: Referral]

A **SAR Referral** is the formal process of notifying the local SAB that an adult may meet the criteria for a SAR under Section 44 of the Care Act 2014.

Why is it needed?

- **Legal requirement:** The Care Act places a duty on SABs to arrange a SAR when an adult with care and support needs dies or experiences serious harm, and there is concern about how agencies worked together.

Each SAB should have its own SAR referral form designed to capture the information required locally, while aligning with the SCIE Quality Markers and incorporating learning from national SAR analyses.

Where organisations operate across multiple SABs or local authority boundaries, this guide encourages regional collaboration to explore standardising referral forms.

Standardisation can help to:

- **Reduce duplication** for agencies working across different local authorities..
- **Improve clarity and consistency** for partners navigating multiple processes.

[1] SMART stands for **Specific, Measurable, Achievable, Relevant, and Time-Bound**, providing a clear framework for setting objectives that are realistic and trackable

An example of this approach is the Greater Manchester SAR Referral Form which was developed by the 10 local SABs, which demonstrates how regional standardisation can support shared learning and streamlined processes. It has also enabled some regional data to be collected to understand the demographics and themes coming from the referrals and reviews.

SAR referrals are most commonly submitted by partners of the local SAB. However, referrals may also be made directly by the adult concerned, by family members or carers, or by members of the public. Regardless of who submits the referral, the same transparent SAR process must be followed to ensure fairness, consistency, and accountability.

It is considered good practice to offer the referrer an opportunity to share their views on how agencies worked together at the screening stage. These insights can then be presented to the panel as part of the decision-making process. Gathering the perspectives of all those involved supports a more informed and balanced assessment and helps ensure that decisions reflect the fullest possible understanding of the circumstances.

15.2 What a Good-Quality SAR Referral Looks Like

A high-quality SAR referral provides clear, concise, and relevant information that enables the local SAB to understand the circumstances, identify potential learning, and determine whether the statutory criteria may have been met. A good referral typically includes:

1. Clear Identification of the Adult

- Full name, age, care and support needs
- Key demographic information
- Legal status (e.g., DoLS, deputyship, safeguarding plan)

2. A Factual, Chronological Overview

- A succinct outline of what happened
- The events leading to serious harm or the adult's death
- The roles of agencies involved
- Why the situation is complex or concerning

3. Articulation of Multi-Agency Concerns

- Specific concern about how agencies worked together
- Gaps, delays, communication issues, or systemic barriers

- Where practice did not align with expected standards
- Examples of good practice or positive intervention, where relevant

4. Why a SAR May Be Needed

- Clear link to Section 44 criteria
- Description of potential learning for the system
- Identification of recurring themes (e.g., self-neglect, transitions, mental health)

5. Evidence and Supporting Information

- Records, timelines, and summaries already collated by the referrer
- Details of conversations with the adult or family (where appropriate)
- Confirmation that consent has been considered, sensitively and lawfully

Good referrals avoid assumptions, stay evidence-based, and focus on learning rather than attributing fault. They make it easier for the screening panel to consider the referral transparently and fairly.

How to Respond to SAR Referrals Requiring Further Information

Not all referrals arrive with the level of clarity and detail needed for effective screening. To maintain fairness and transparency, SABs should adopt a supportive, problem-solving approach when referrals lack essential information.

1. Provide Feedback and Request Clarification

If key details are missing, unclear, or inaccurate, the SAB should:

- Inform the referrer promptly and clearly
- Specify exactly what additional information is required
- Avoid rejecting referrals prematurely where statutory criteria *may* still apply

A constructive feedback loop helps improve practice across the system.

2. Offer Support and Guidance

The SAB should direct the referrer to:

- Written guidance
- Example referral templates
- Training or briefing sessions

- Opportunities to discuss the case with the SAB office

This is especially important for smaller agencies, voluntary organisations, or members of the public.

3. Ensure Referrals from Members of the Public Are Handled Proportionately

Public referrals may lack professional detail. Instead of expecting formal documentation, SABs should:

- Focus on the substance of the concern
- Seek additional information from agencies already involved
- Avoid placing burdensome expectations on families or carers

4. Maintain a Consistent and Transparent Process

Even when referrals are unclear or incomplete, SABs must:

- Consider the information *that is available*
- Apply Section 44 criteria explicitly
- Record the rationale for all decisions
- Communicate the outcome in plain, accessible language

This ensures openness, fairness, and accountability.

5. Promote Continuous Improvement

Patterns of repeated poor-quality referrals may indicate:

- Training needs
- Systemic misunderstanding of SAR criteria
- A lack of confidence among practitioners
- Cultural barriers to escalation

SABs should use this intelligence to shape learning events, practitioner forums, or updated guidance.

All SAR referrals must be considered explicitly against the statutory criteria set out in **Section 44 of the Care Act 2014**. The rationale for the decision—whether the criteria for a SAR has been met or not—must be clearly recorded. This ensures that every referrer, whether a professional, adult or a member of the public, receives an understandable explanation of how and why the decision has been made.

When engaging with the referrer, a key message underpinning all SAR activity is that the purpose of a SAR is **learning**. SARs are not about attributing blame to individuals or organisations; they are about understanding what happened, identifying what can be improved, and strengthening safeguarding arrangements across the local system. Emphasising learning helps create a culture in which partners, practitioners, and the wider community feel confident in raising concerns and participating openly in reviews.

It is recognised as good practice for local SABs to provide accessible, public-facing information that explains what a SAR is, the statutory criteria, and when a referral may be appropriate. Clear, plain-language guidance—particularly on SAB websites—supports members of the public, families, carers, and community organisations to understand the role of SARs and how to make a referral. This transparency promotes trust, empowers communities, and ensures that safeguarding learning is shared widely and meaningfully.

15.3 Screening of SAR Referral: National Context and Best Practice

Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SABs) must commission a Safeguarding Adults Review (SAR) when:

- An adult with care and support needs has died or experienced serious harm.
- Abuse or neglect is known or suspected.
- There is concern that partner agencies could have worked more effectively to safeguard the adult.

Although each SAB may operate its own local process for screening SAR referrals, the underlying principles of best practice remain consistent across England. This includes engaging the adult (where possible) and their family at an early stage, seeking agencies' initial views, and applying a **proportionate, ethically sound approach to requesting and reviewing information**.

The Importance of Single-Agency Information in Proportionate Decision-Making

To reach a fair and well-informed decision about whether the SAR criteria are met, SABs must have a clear understanding of the adult's lived experience and the extent to which agencies worked individually and collectively to safeguard them. This requires **targeted, proportionate requests for information from single agencies**.

Proportionate information-gathering does **not** mean requesting full chronologies or extensive documentation at the outset. Instead, it involves asking agencies for concise, high-level summaries that enable the SAB to:

- Build an early picture of the adult's life, needs, vulnerabilities, and strengths.
- Understand the nature and frequency of agency involvement.

- Identify any known or suspected abuse or neglect.
- Consider what multi-agency working looked like in reality, and whether there are indications that practice could have been more effective.
- Ensure the adult's voice—or that of those who knew them well—is recognised and not lost in procedural analysis.

A proportionate approach avoids unnecessary burden on agencies, ensures that the screening process remains timely, and supports transparent, defensible decision-making. This early information is foundational: without it, SABs risk either progressing to a SAR without sufficient justification or, alternatively, missing opportunities for critical system learning.

> "It was good to see things set out chronologically. The process provided an understanding of the events that took place and what might have led to a different outcome. It offered a form of closure – what was (not) done, what could have been changed and what had really happened. For example, why it took over a year for our mother to get help, and the back and forth of referrals"
> (Family Member)

Best Practice Principles

Timely Screening

- Initial screening completed within **5 working days**.
- A clear decision ideally reached within **4 weeks**.
- Early clarity supports planning, maintains momentum, and prevents delays in learning.
- Wherever possible, the adult's voice—and/or their family's—should be sought, understood, and recorded in relation to how agencies worked together.

Multi-Agency Decision-Making

- Screening discussions should involve the Local Authority, Police, Health representatives, and any other relevant partners.
- Deliberations should explicitly consider how the adult's wishes, views, or experiences informed partner agencies' actions.
- Decision-making should reflect shared accountability, balanced professional judgement, and careful consideration of risk.
- A clear written record must be kept for accountability, transparency, and auditability.

15.4 SAR Decision Making Flowchart

[SCIE, Quality Marker 2: Decision Making]

Under the Care Act 2014, it is the local SAB that holds the statutory responsibility for deciding whether the criteria for a SAR have been met.

Section 44 of the Act sets this out clearly, stating that:

"A SAB must arrange for a review of a case involving an adult in its area with needs for care and support [...] if certain conditions are met."

This places the decision-making duty squarely with the SAB, ensuring that SARs are commissioned consistently, transparently, and in line with national legislation.

Who Makes the Decision?

In practice the approach may vary across the country, however a SAR Subgroup—a multi-agency group established by the SAB—typically undertakes the initial assessment of referrals and determines whether the statutory criteria are met. However, this decision is not final until formally ratified by the Independent Chair of the SAB.

This approach ensures:

- Appropriate governance, accountability and transparency in decision-making.
- That the decision is defensible and aligned with statutory guidance.
- That the SAB as a whole maintains oversight of its legal responsibilities.

Each local SAB should be encouraged to develop a SAR Decision-Making Flowchart based on the legal framework set out in the Care Act 2014. This tool supports consistency and transparency in decision-making by providing a clear rationale for whether the statutory criteria for commissioning a SAR have been met.

The flowchart should be underpinned by the criteria defined in Section 44 of the Care Act 2014 and guide practitioners through the key considerations. Using this approach ensures decisions are evidence-based, proportionate, and clearly documented, helping partners understand why a SAR is required—or why it is not.

Examples from local SAB's:

- **Salford SAB** – SAR Decision Making Flowchart

Decision making should be timely to ensure learning has been identified and taken forward at the earliest opportunity.

There are three possible outcomes:

- A legal duty arises either when the **Mandatory criteria has been met under Section 44** or when the SAB chooses to exercise **Discretionary duty under Section 44 (4)** (Care Act 2014, Section 44)
- There is **no legal duty**, but there is individual agency learning to be achieved and **assurance** may be requested. Seeking assurance is a statutory duty of the SAB as per Care and Support Statutory Guidance, paragraph 14.133)
- There are **no concerns** requiring further action to be taken by the local SAB.

Once the Independent Chair has signed off the decision:

- Notify the referrer of the outcome promptly.
- Update agencies that submitted reports or information, outlining the decision and next steps.
- Inform other relevant professionals or bodies (e.g., the Coroner, if applicable) to ensure coordination.

This approach promotes transparency, supports multi-agency learning, and ensures all stakeholders remain engaged.

Defensible Decision-Making - to ensure decisions are robust and transparent:

- Document the rationale, including application of statutory criteria and Making Safeguarding Personal (MSP) principles.
- Record how the adult's voice influenced the decision.
- Maintain accessible records for audit and accountability.

Feedback and Communication

- Provide clear, timely updates to referrers, adult and families on any outcomes and next steps.
- Explain decisions in plain language, acknowledging the adult's perspective.

Proportionality

- Match the review process to the complexity of the review.
- Consider alternative reviews (e.g. Domestic Abuse Related Death Reviews (DARDR), LeDeR where appropriate.

Why This Matters

- **Consistency:** Across reviews and agencies.

- **Accountability:** Decisions aligned with statutory duties and MSP principles.
- **Learning:** Opportunities for improvement are not missed.
- **Trust:** Families and professionals have confidence in the process.

Interface with Coroners

- Inform the Coroner if a SAR referral is received and outcome to whether the criteria have been met and then share indicative timescales.
- Refer to National SAB Guidance on the Interface between SARs and Coronial Processes (National Business Manager Network, Sept 2024).

15.5 Outcome of the decision making process

Providing feedback to the referrer and to any agencies that contributed information is an essential part of a transparent and accountable SAR process. Informing them of the outcome ensures they understand whether the statutory criteria have been met and what the next steps will be. This supports open communication, maintains trust in the local SAB, and demonstrates that their contribution has been considered carefully and respectfully.

Timely feedback also enables agencies to prepare for any further involvement if a SAR is progressing, or to take forward alternative learning actions if the criteria have not been met. It ensures that key partners remain engaged, reduces uncertainty, and supports effective multi-agency learning. Clear communication of the decision and rationale helps strengthen partnership working, reinforces defensible decision making, and ensures that learning pathways—whether a SAR or another process—are understood and acted upon.

15.6 SAR Timelines and Promoting Timely, Defensible Reviews

[SCIE, Quality Marker 7: Management of Process]

Under the Care Act 2014, SABs must ensure that SARs are conducted in a timely, proportionate, and transparent manner.

“The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort should be made while the SAR is in progress to capture points from the review about improvements needed; and to take corrective action.” (Care and Support Statutory Guidance, paragraph 14.173)

The Care Act 2014 and its accompanying Care and Support Statutory Guidance establish the legal foundation for SARs. However, they do not define a clear starting

point for SAR timelines. While the guidance recommends completion within a "reasonable period"—commonly interpreted as **six months**—there is **no statutory definition** of when this period begins.

This ambiguity has led to inconsistencies across SABs.

Some Boards begin the timeline at the point of referral acceptance, others at the agreement of Terms of Reference, and some when the reviewer begins their work. The latter is often the most practical and defensible starting point, as it signals the beginning of substantive review activity.

Delays in the SAR process are sometimes **unavoidable**. Common contributing factors include:

- **Difficulties in commissioning a suitable reviewer or author**
- **Parallel processes:** such as criminal investigations, Domestic Abuse Related Deaths Reviews (DARDR), or LeDeR reviews
- **Review complexity**: requiring extended scoping or multi-agency coordination
- **Complex situation**: where reviews are particularly complex, a longer timeframe may be necessary. This should be clearly justified, with revised timelines agreed and communicated.
- **Supporting the adult and/or their families:** reviews need to go at their pace due to the often difficult circumstances they are dealing with.

In such situations, **positive delay**—where postponement is purposeful, documented, and in the interest of quality or sensitivity—is acceptable. Conversely, **negative delay**, stemming from poor planning or communication, is not.

To promote **timely, transparent, and defensible SARs**, SABs should:

- **Clearly document** the start and end points of each SAR, including justifications for any delays.
- **Establish internal benchmarks** for each phase (e.g., commissioning, scoping, engagement, reporting).
- **Utilise SAR trackers or dashboards** to monitor progress and identify delays early.
- **Streamline commissioning processes**.
- **Coordinate with parallel reviews** to reduce duplication and delay
- **Maintain regular communication** with families and partner agencies to foster transparency and trust.
- **Progress Monitoring**: SABs should regularly monitor progress and ensure that any delays are documented and explained.

15.7 Commissioning Arrangements for SARs

[SCIE, Quality Marker 5: Commissioning]

SABs may continue to use local or internal commissioning procedures—such as contracts, frameworks or Terms of Reference—and this is entirely appropriate; however, where no formal process exists, it is considered good practice to issue a commissioning letter to ensure clarity from the outset, avoid misunderstandings, and provide assurance that data protection, confidentiality and safeguarding standards will be upheld.

Local Authorities, as statutory SAB partners, typically lead commissioning arrangements and must ensure that the process is compliant with procurement and governance frameworks. In line with the Care and Support Statutory Guidance (paragraph 14.172), SABs must appoint reviewers who possess the **appropriate skills, experience and independence** to conduct a robust and credible review.

It would be seen as good practice for individual SABs to have a commissioning letter in place when a review is commissioned to prevent any misunderstandings and ensure all parties are aligned from the outset. It will also provide an agreed understanding and assurance that data protection, confidentiality, and safeguarding standards will be upheld.

The Care and Support Statutory Guidance, paragraph 14.172 emphasises that SARs must be led by individuals with appropriate skills, experience, and independence.

Suggested Contents for a SAR Commissioning Letter

Header and Introduction	• Name and address of the Independent Reviewer. • Name and address of the commissioning local SAB. • Date of the letter. • Subject: *Commissioning of Independent Reviewer for a SAR*.
Purpose of the Letter	• State that the letter serves as a formal agreement to commission the reviewer. • Reference the statutory basis under **Section 44 of the Care Act 2014**.
Scope of the Review	• Brief description of the adult (anonymised). • Objectives and learning aims of the SAR. • Skills and experience needed as a reviewer • Expected outputs (e.g., final report, executive summary, presentations).
Roles and Responsibilities	• **Responsibilities of the Independent Reviewer:** – Role within the review, for example chairing panel meetings. – Conducting the review in line with agreed methodology. – Engaging with the adult, families and professionals.

	– Producing a high-quality, anonymised report. – Adhere to SCIE SAR Quality Markers – Follow internal governance processes for sign off. – Produce a 7mb, Exec Summary or support any events etc to share the learning. • **Responsibilities of the SAB:** – Providing access to records and contacts. – Coordinating agency involvement. – Offering administrative and legal support.
Timescales and Milestones	• Start and end dates. • Key milestones (for example draft report, feedback from partners, final report). • Flexibility clauses for extensions if needed.
Fees and Payment Terms	• Agreed fee (inclusive or exclusive of VAT). • Payment schedule (for example 50% on commencement, 50% on completion). • Invoicing instructions.
Confidentiality and Data Protection	• Requirement to comply with **UK GDPR** and **Data Protection Act 2018**. • Secure handling and storage of sensitive information. • Non-disclosure of identifiable information without consent.
Intellectual Property and Publication	• The final report and all review materials are the property of the SAB. • Only the SAB has authority to publish or disseminate the findings. • Reviewer authorship may be acknowledged in line with SAB policy. • Reviewers must not use or share any SAR content or learning before publication.
Termination Clause	• Conditions under which either party may terminate the agreement. • Notice period and obligations upon termination.
Signatures	• Signature of the Independent Reviewer. • Signature of the SAB Chair or delegated officer. • Date of signing.

Please note – if local SAB's develop any commissioning letter, it is recommended that it is reviewed by your internal legal services and relevant departments to ensure local compliance with statutory requirements and organisational policies.

15.8 SAR Review Panel/Group

Once the SAB confirms that the statutory criteria for a SAR have been met, the SAB will need to establish a Multi-Agency SAR Review Panel/Group (names may vary locally).

This group is responsible for overseeing the review process and ensuring that it is:

- **Collaborative:** Includes representatives from all relevant and specialist agencies involved with the adult.
- **Person-Centred:** Embeds Making Safeguarding Personal principles by considering:
  - The adult's voice, wishes, and priorities.
  - How the adult (or their family/advocate) can contribute to shaping the review.
- **Transparent:** Maintains clear documentation of decisions and actions.
- **Learning-Focused:** Ensures the review identifies systemic improvements rather than attributing blame.

Key Functions of the SAR Review Group

- **Agree the terms of reference,** including how the adult's perspective will be represented.
- **Commission an independent reviewer** where appropriate.
- **Decide on the methodology** (e.g., traditional review, learning event, hybrid approach).
- **Monitor progress** and ensure timely completion.
- **Communicate with families and referrers throughout,** using clear and compassionate language.
- **Take the final report through local governance for acceptance and sign off**
- **And depending on local process, develop an action plan to implement the learning.**

15.9 Chairing the SAR Review Panel/Group: Eligibility and Responsibilities

Who Can Chair a SAR Review Panel/Group?

The Chair is typically a senior professional with safeguarding expertise. They need to be independent and not directly involved in the care or management of the adult concerned. In some areas, the Chair may be:

- A member of the SAB with sufficient seniority and neutrality.
- A designated SAR Subgroup Chair within the SAB structure.
- An external independent professional, especially for complex or high-profile reviews
- The Independent Reviewer or Author of the SAR Report.

Responsibilities of the Chair of the Review Panel/Group

- Lead and coordinate the SAR process, ensuring it adheres to statutory guidance and local protocols.
- Facilitate meetings, ensuring inclusive and respectful dialogue.
- Manage any declaration of interest or conflict, including any disagreements between panel members and escalate to the SAB Chair (if required)
- Ensure the terms of reference are clear, agreed and addressed within the final report.
- Oversee the commissioning of the independent author and ensure their work is supported.
- Manage the interface with other reviews (e.g., criminal investigations, inquests).
- Ensure the review group agree that the final report is accurate, balanced, and reflects the learning identified.
- Support the dissemination of findings and ensure recommendations are translated into SMART[2] action.

The Chair of the Review Group plays a pivotal role in maintaining the focus on learning, avoiding hindsight bias, and ensuring the review is conducted in a transparent, proportionate, and timely manner

15.10 Membership of the SAR Panel/Review Group

Members typically include senior representatives from statutory partners and relevant agencies and must be senior enough to support decision making and influence policy change within their organisation.

Members' responsibilities include:

Governance and Oversight

- Agreeing the terms of reference and scope of the review.
- Ensuring the review is conducted in line with statutory requirements and agreed methodology.
- Managing the interface with parallel proceedings (e.g., criminal investigations, inquests).

Critical Analysis and Learning

- Scrutinising and analysing all submitted information.
- Feeling confident in positive challenge to partners to identify what could have been done differently.
- Supporting the Independent Reviewer in drafting the SAR report.
- Supporting the Independent Reviewer of the report to make recommendations or ask questions to the SAB for practice improvement and systemic change.

Professional Conduct and Representation

- Panel members must:
  - Be senior enough to represent their organisation.
  - Where possible, not have been directly involved in the care or management of the adult concerned
  - Ensure information flow between the panel and their organisation.
  - Attend all meetings and prepare thoroughly.
  - Nominate deputies only in exceptional circumstances to maintain continuity.
  - Be the link between the review and the Senior Leadership Team within their own organisation to ensure they are kept updated and have oversight of the progress of the SAR.
  - Ensure at the end of the process any internal governance is undertaken before final sign off.

Promoting Multi-Agency Learning

- Contribute to identifying effective practice and areas for improvement.
- Support dissemination of learning across agencies.
- Ensure recommendations are translated into SMART[2] actions and monitored for implementation.
- Engage with the SAB to ensure actions and learning is shared and implemented into practice.
- Provide assurance post completion of the actions that have been embedded into practice and evidence the impact of the learning/actions.

It's important that the SAR Review Group provides the Independent Chair with regular updates on the progress of the SAR to ensure there is strategic oversight because they hold ultimate accountability to ensure statutory duties are met.

15.11 Terms of Reference for a SAR

[SCIE, Quality Marker 4: Clarity of Purpose]

Each SAR needs a Terms of Reference (ToR) because it provides a clear framework for what the review will cover and how it will be conducted. (Care and Support Statutory Guidance 14.166)

It sets out the purpose, scope, and key questions, ensuring that all agencies, practitioners, and families understand the objectives and approach. Without this clarity, the review risks becoming unfocused or inconsistent.

The ToR also embeds Making Safeguarding Personal principles, specifying how the adult's voice and experiences will be included and respected. This is essential because SARs are about learning from real lives, human stories, not just systems.

The ToR sets the framework for the SAR by clearly defining roles, responsibilities, confidentiality expectations, and reporting arrangements. This clarity reassures everyone involved that the process is fair, transparent, and focused on learning rather than blame. By establishing how the review will be conducted, the ToR ensures that the approach remains structured and proportionate, supporting meaningful exploration of systemic issues, good practice, and opportunities for improvement. Crucially, it keeps the SAR centred on learning — not investigation — while respecting the perspectives and experiences of the adult and their family.

According to SCIE, the ToR also supports governance by aligning the SAR with the strategic objectives of the local SAB, promoting multi-agency collaboration and ensuring legal and procedural clarity.

It is also best practice for the Terms of Reference to explicitly address Equality and Diversity, including considerations of protected characteristics and intersectionality. This reflects the learning from the Second National SAR Analysis and ensures that reviews fully explore how structural inequalities and individual characteristics may have shaped the adult's experiences, risks, and outcomes.

"Why did they say 'terms of reference'? What does that mean to the layperson? Speak in plain English to family members."

(Family member)

Its important to note that a SAR must not speculate on the cause of death; where the cause has not yet been established at inquest, the review should limit itself to verified facts and avoid drawing conclusions that fall within the Coroner's remit.

Please note that *'Terms of Reference'* is professional language that adults or family members involved in a SAR may not immediately recognise or understand. Practitioners and Reviewers should therefore take time to explain what the term means and how it

guides the review, using simple, clear and accessible language to support meaningful engagement.

Best Practice for SAR Terms of Reference (ToR)

Clear Purpose and Scope	• Define **why** the SAR is being conducted. • What **type of abuse** is being explored? • Specify the **timeframe** and **events** under review. • Clarify **which agencies and individuals** are involved, taking into consideration specialist advisors. • Discussion about how, if requested, AI can be used to support the process.
Focus on Learning, Not Blame	• Emphasise that the SAR is about **systemic learning** and **improvement**, not assigning fault. • Use language that promotes **reflection and openness**.
Consideration to be given to Parallel Processes	• Are there other processes to consider?
Voice of the Adult, view of the family or representative	• Who was the adult? • Social History. What is the human story? • Consideration of **Protected Characteristics** including **Equality, Diversity and Inclusion** (Equality Act 2010). • How can the family be involved in the review? • Is there consideration to be given to communication needs? • Is support from advocacy services required?
6 Safeguarding Principles (Care Act 2014 Statutory Guidance, Chapter 14)	These six principles apply to all sectors and all agencies involved in safeguarding adults: **1. Empowerment – "People being supported and encouraged to make their own decisions and informed consent."** – Focuses on **choice**, **control**, and ensuring the adult's voice is central. **2. Prevention – "It is better to take action before harm occurs."** – Proactive work, early identification, and reducing risk before abuse or neglect happens. **3. Proportionality – "The least intrusive response appropriate to the risk presented."** – Responses should be **balanced**, **least restrictive**, and tailored to the adult's circumstances.

	4. Protection – "Support and representation for those in greatest need." – Adults who are at risk receive **support, advocacy**, and effective interventions. **5. Partnership – "Local solutions through services working with their communities."** – Agencies work together, share information appropriately, and build community resilience. **6. Accountability – "Accountability and transparency in delivering safeguarding."** – Clear roles, responsibilities, governance, and scrutiny across all organisations.
Inclusion of Key Questions	Frame questions that guide the review, such as: – What happened? – What could have been done differently? – What was done well? – What are the lessons for future practice?
Engagement of Frontline Practitioners	• Outline how practitioners will be involved (e.g., interviews, learning events). • Ensure their voices and experiences are central to the review.
Reference to Legal and Statutory Duties	• Cite relevant sections of the **Care Act 2014**, especially Section 44. • Include requirements and expectations from **Care and Support Statutory Guidance**.
Defined Roles and Responsibilities	• Identify the SAR lead/reviewer, SAB members, and agency contacts. • Clarify who will coordinate, support, and quality assure the process
Timelines and Milestones	• Set realistic but clear **deadlines** for each stage of the review. • Take into consideration any external factors that might cause delay. • Include time for **consultation**, **drafting**, and **dissemination**.
Confidentiality and Consent	• Address how **personal information** will be handled. • Include provisions for **consent**, **anonymity**, and **data protection**.

Methodology	• Describe the **approach** (e.g., thematic analysis, systems methodology). • Include how evidence will be gathered and validated. • Discussion and agreement on the style of reporting writing should be used for the SAR.
Publication	• What are initial thoughts about publication?. • What information can or cannot be shared? • What type of report is needed, full report, learning focus report, briefing document etc?.
Governance and sign off	• What are the stages for signing off before the SAB's final decision? • How will any differences of opinion be addressed and managed—whether between participating agencies, between the author and those agencies, or between the author and the SAR Review Group and/or Board?
Dissemination and Implementation of Learning	• Plan for how findings will be **shared** with stakeholders. • Include mechanisms for **embedding learning** into practice.
Management of Communications and Media	• Who will prepare a press release? • Who will coordinate responses to media enquiries?

15.12 When the Adult's or Family's Voice Diverges from the SAR Terms of Reference

The **Terms of Reference (ToR)** provide structure and focus for a SAR, ensuring that the review meets statutory requirements and addresses key learning objectives. However, it is not uncommon for the adult or their family to raise concerns, experiences, or perspectives that **fall outside the agreed scope** of the review.

Balancing Structure with Responsiveness

- **Acknowledge divergence respectfully**: When individuals raise issues beyond the ToR, these should be acknowledged as valid and important, even if they may not be able to be fully explored within the SAR. This helps maintain trust and shows that their voice is being heard.
- **Clarify the purpose and limitations of the SAR**: Provide clear, compassionate explanations about what the SAR can and cannot cover. This helps manage expectations and reduce frustration.
- **Consider flexibility in the ToR**: Where appropriate, the SAR panel may choose to adapt or expand the ToR to incorporate emerging themes raised by the adult or family—especially if they reveal systemic issues or missed learning opportunities.

- **Document and signpost**: If concerns fall outside the scope of the SAR, its important that they are documented and, where possible, signposted to other processes (e.g. complaints procedures, regulatory bodies, or advocacy services).
- **Use reflective supervision**: given the feedback from the adult or their family, reviewers and panel members should reflect on whether the ToR is too narrow or whether unconscious bias may be influencing decisions about what is considered "relevant."
- **Transparency in reporting**: The final SAR report should include a section that acknowledges any divergence between the ToR and the views of the adult or family, explaining how this was handled and why certain issues were or were not included.

16. SAR Methodologies

16.1 Methodological Flexibility and Good Practice

[SCIE, Quality Marker 9: Assembling Information]

The Act and the accompanying Care and Support Statutory Guidance (paragraphs 14.164 and 14.170) intentionally stop short of prescribing a specific methodology. Instead, they provide SABs with a **purposefully adaptable framework** that allows reviews to be shaped according to the circumstances of each review.

This flexibility enables Boards to select methodologies that are **proportionate and context-specific**, ensuring the review focuses on the learning required rather than defaulting to lengthy or resource-intensive processes. It also allows SABs to tailor the design of each review to its complexity, purpose, and learning aims, including the option to adopt **hybrid or blended approaches** that draw on recognised models.

By taking advantage of this adaptable framework, SABs can ensure that review processes remain **inclusive, timely, and responsive** to the unique features and learning needs of each situation, ultimately supporting meaningful learning and system improvement.

The methodology which is identified may differ if the adult has passed away or is alive.

A high-quality SAR does **not** require starting from scratch.

This "**build, don't replicate**" approach not only avoids duplication but increases the likelihood of meaningful, sustained improvement.

16.2 What are SAR Methodologies?

SAR methodologies are structured approaches used to conduct individual reviews. They outline how information is gathered, analysed, and presented to identify learning and improve practice. Common methodologies include systems-based reviews, learning event approaches, and thematic analysis.

Why are they Important?
Choosing the right methodology ensures the review is proportionate, transparent, and focused on learning rather than blame. It helps capture the complexity of multi-agency working and promotes meaningful engagement with adults, families, and practitioners.

One of the consistent recommendations in the Second National Analysis of SARs in England (2019–2023) is that SABs should avoid treating every SAR as a standalone exercise. Instead, SABs should adopt an approach that:

- Reviews relevant previous SARs locally and nationally.
- Maps recurring themes to existing action plans.
- Identifies what has already been implemented and what remains outstanding.
- Focuses recommendations on embedding, strengthening, and evaluating impact, rather than creating new lists of actions.

This approach is more effective and avoids action fatigue. It also aligns with the principles of continuous improvement and quality assurance.

Why is a Flexible Approach Needed?
No single methodology suits every SAR. The circumstances of the adult, the number of agencies involved, and the complexity of the issues all require a flexible and tailored approach. Adapting the methodology ensures that the review remains person-centred, culturally sensitive, and proportionate to the level of learning required. It also allows review teams to recognise learning that has already taken place and to assess where further strengthening may be needed.

Proportionality is central to this decision-making. SABs should consider proportionality not only when selecting a methodology, but also when defining the scope of the review, the learning objectives, and the depth of analysis required. Proportionate does not mean less rigorous; rather, it means ensuring that:

- the review answers the learning questions most important to safeguarding adults
- resources (time, cost, practitioner input) are used wisely
- reports remain accessible, practical, and improvement-focused
- the process does not overwhelm families or professionals

Proportionality also aligns well with strengths-based and appreciative approaches, supporting constructive, balanced, and forward-looking learning.

The Value of Diverse Perspectives

An effective SAR methodology should not only examine past events but also seek insights into current safeguarding practice. Including diverse perspectives—such as

those of practitioners, operational managers, and senior leaders—can provide a richer understanding of what works well and what challenges persist today in situations similar to those under review. Hosting an event or forum to gather these views can highlight systemic issues and inform recommendations that are both relevant and actionable. This approach ensures that learning is forward-looking, prioritising changes that will have the greatest impact on improving safeguarding outcomes.

The Importance of Highlighting Good Practice in SARs

SARs are often associated with identifying what went wrong, but it is equally important to recognise and highlight examples of good practice.

Doing so serves several critical purposes:

- **Promotes Learning and Confidence**: Showcasing effective practice reinforces what works well and encourages professionals to continue applying these approaches.
- **Balances the Narrative**: Acknowledging strengths alongside areas for improvement creates a fair and constructive review process, avoiding a culture of blame.
- **Informs Systemic Change**: Good practice examples can be scaled and embedded across agencies, helping to strengthen safeguarding systems.
- **Supports Professional Morale**: Recognising positive contributions validates the efforts of practitioners and fosters a culture of continuous improvement.

By capturing and sharing good practice, SARs become a tool not only for addressing shortcomings but also for celebrating success and driving innovation in safeguarding.

A Model of Good Practice - Cumbria SAB:

CSAB Safeguarding Adult Review (SAR) Methodology Toolkit.pdf

The **Cumbria Safeguarding Adults Board (CSAB)** has developed a comprehensive **SAR Methodology Toolkit**, offering a range of methodologies that SABs can adopt or adapt. These include:

- **Systems Analysis**: Reviewer-led, using integrated chronologies and contributory factor analysis. Effective for complex reviews and familiar to health sector partners.
- **Learning Together**: Developed by SCIE, this model uses research questions and reflective case groups to identify systemic patterns.
- **Measurement of Change Analysis**: A desktop audit approach that tests whether previous SAR learning has been embedded, using Key Lines of Enquiry (KLOE).

- **SAR in Rapid Time**: A streamlined methodology using SCIE templates to produce learning quickly, ideal for reviews where learning needs to be identified quickly due to emerging risks.

Cumbria's toolkit supports both mandatory and discretionary SARs,. emphasises **methodological flexibility**, ensuring the chosen approach is the "best fit" for the review.

Please remember, regardless of what methodology is used, the experience of the adult should **always remain c**entral to the review. Methodologies that incorporate **family engagement**, **1:1 conversations**, and **multi-agency perspectives** ensure that the review honours the individual and reflects on:

- What went wrong.
- What went right.
- What could be done differently.

This person-centred approach transforms SARs from procedural exercises into meaningful reflections that drive change.

16.3 Methodology When the Adult Is Alive

When the adult at the centre of a SAR is alive, the methodology used will often require a more nuanced and flexible approach. Unlike reviews concerning adults who have died, practitioners must consider how the review process may directly affect the individual's wellbeing, autonomy, emotional safety, and ongoing involvement with services.

This means that, while the core purpose of a SAR remains the same—to identify learning, improve practice, and strengthen systems—the *way* in which the review is carried out may need to be adapted.

Key Considerations

1. Impact on the Adult
The review must take into account the potential impact on the adult's life, both during and after the process. This includes their emotional response, sense of agency, possible re-traumatisation, and any effect on their current care or support arrangements. Engagement should be sensitive, consent-based, and paced according to the adult's needs and circumstances.

2. Involvement and Participation
The adult may wish to be actively involved, minimally involved, or not involved at all. The methodology should be flexible enough to honour their preferences while still enabling

learning. Practitioners must consider communication needs, accessibility, cultural factors, and the adult's capacity and fluctuating capacity.

3. Process Adaptation
Traditional methodologies may need adjusting to ensure the adult's safety and comfort. For example, interview formats, timelines, and the coordination of multi-agency meetings may be adapted to reduce stress, avoid duplication, and maintain trust and transparency. Professionals should continually assess the balance between obtaining meaningful learning and safeguarding the adult's rights and welfare.

4. Considering the Before, During, and After
Reviews involving adults who are alive must reflect the full timeline of their lived experience:

- **Before** — what was happening in the adult's life and what responses were offered by services
- **During** — how agencies worked together in real time, including critical points where practice or decision-making influenced outcomes
- **After** — how the safeguarding response affected the adult's ongoing safety, wellbeing, and perception of services

Understanding this journey helps ensure that conclusions are grounded in the reality of the adult's experiences, not just professional accounts.

Drawing Conclusions

When concluding a SAR where the adult is alive, the review must bring together the learning from multiple perspectives—including the adult's own narrative, where they choose to share it. Conclusions should reflect:

- the adult's lived experience
- professional decision-making and system influences
- strengths and areas of good practice
- opportunities for improvement across agencies

The focus should always be on meaningful learning and system improvement while upholding the adult's dignity, rights, and unique story.

For further information about Publication When the Adult Is Still Alive – see section 24.3.

16.4 Choosing the Right Methodology

Selecting the most appropriate methodology is a critical early decision when commissioning a SAR.

Choosing the right methodology requires SABs to balance the purpose of the review, the complexity, and the type of learning that needs to achieved. There is no single 'right' approach.

Consideration should be given to family involvement, the legal context, available resources, urgency of learning, and any public interest issues. SABs should also reflect on previous local and national learning to avoid duplication and determine whether a thematic or hybrid approach may be more effective. By aligning the methodology with these influencing factors, Boards can commission reviews that are proportionate, inclusive, timely, and focused on driving meaningful system improvement.

Key Considerations When Determining Methodology

1. Complexity and Nature of the adult's circumstances

The scale and complexity of the circumstances should guide methodological choice.

- Reviews involving multiple agencies, serious harm, or highly complex timelines may require more structured systems-based approaches.
- In contrast, reviews with narrower scope or less complexity may be better suited to desktop reviews, rapid methodologies, or focused learning events.

2. Purpose and Learning Objectives

The starting point should always be: What do we need to understand from this review? Clarity of learning objectives helps SABs identify whether the review needs to explore:

- systemic issues,
- practice decision-making,
- communication pathways,
- or wider patterns of organisational behaviours

Some learning aims may be better met through reflective workshops or thematic approaches.

3. Engagement With Adults, Families, and Practitioners

When person-centred engagement is a priority, methodologies that create space for meaningful involvement—such as Learning Together, Appreciative Inquiry, or facilitated conversations—may be most appropriate. SABs should consider:

- the adult's wishes and capacity,
- the family's expectations and availability,

- and how different methodologies influence the tone and experience of involvement.

4. Legal, Ethical, and Procedural Context

Parallel investigations (e.g., criminal proceedings, inquests, disciplinary processes) may limit what can be shared or discussed.

Methodologies may need adjusting to ensure:

- information can be lawfully exchanged,
- agencies remain confident in participating,
- and the review does not interfere with legal processes.

5. Timeframes, Resources, and Urgency of Learning

SABs must consider whether urgent learning is required to inform current practice.

- Rapid reviews, including SCIE's Review in Rapid Time, are suitable where swift learning is essential.
- More in-depth methodologies are appropriate where deeper systemic analysis is needed and timescales allow.

6. Public Interest and Transparency

In high-profile cases or where public confidence is at stake, more formal and structured methodologies may be necessary. These approaches:

- provide robust analysis,
- demonstrate transparency,
- and support clear public communication of the learning.

7. Existing Learning and Local Context

SABs should assess whether:

- similar issues have emerged in previous SARs,
- a thematic approach would generate broader learning,
- or hybrid methodologies could build on existing insights.

Local safeguarding culture, experience with particular methodologies, and the maturity of quality assurance processes will also influence the best approach.



Examples of Methodologies

Methodology	**Focus**	**Use**	**Strengths**
Chronology-Based Review	Timeline of events	Complex, multi-agency reviews	Clear sequence of actions
Systems Approach (e.g. SCIE Learning Together)	Systemic issues	Deep learning from practice	Promotes culture change
Multi-Agency Learning Event	Practitioner-led reflection	Engagement and shared learning	Builds trust and understanding
Desktop Review	Document analysis	Lower complexity reviews	Quick and cost-effective
Hybrid Approach	Tailored combination	Complex or unique reviews	Flexible and adaptive
Appreciative Inquiry	What works well	Good practice reviews	Celebrates strengths and innovation – enable the practitioners to have a voice in the review
Thematic Review	Common themes	Multiple related reviews	Broad systemic learning

Thematic Approaches: When a Broader Lens Produces Stronger Learning

A thematic review examines patterns, insights, and recurring issues across more than one case. It is especially appropriate where several individuals have experienced similar systemic challenges or where the learning lies not in isolated incidents, but in recurring themes across services or pathways.

When a Thematic Approach is Useful

- Several SAR referrals relate to a common type of harm (self-neglect, cuckooing, substance use, homelessness) and/or repetitive practice issues (professional curiosity, mental capacity assessments, multi-agency risk management meetings).
- A single referral reflects previously identified concerns, suggesting cumulative systemic issues.
- The Board wishes to examine how a particular pathway or cohort is being supported across the partnership.

Benefits of Thematic Review

- Avoids duplication by drawing on learning already identified in previous SARs.
- Generates wider system learning that individual reviews may not reveal.
- Supports strategic improvement, providing Boards with a clearer picture of partnership trends.
- Enables efficient use of resources, delivering broader impact than a single review process.

A thematic approach remains entirely compatible with person-centred principles. The lived experience of each adult is still honoured, but the emphasis shifts toward pattern recognition, service interface issues, obstacles to best practice, and system design.

SCIE's Review in Rapid Time (RiRT): A Proportionate, Timely Alternative

The **SCIE Review in Rapid Time (RiRT)** methodology offers a structured but streamlined process for generating learning at pace. It is especially valuable where:

- Immediate learning is required to reduce risk.
- The circumstances are serious but not overly complex.
- Agencies require quick feedback to inform current operational practice.
- There is a need to capture early insights prior to parallel investigations.

Key Features of SCIE's Rapid Review

- A **compressed timescale**—typically 6–8 weeks.
- A clear focus on **what needs to change now**, not historic detail.
- Use of **reflective discussions** with practitioners rather than lengthy reports.
- A concise learning report, often supported by a partnership learning briefing.

Why RiRT Supports Proportionate Decision-Making

A full systems analysis is not always necessary. Rapid reviews:

- Promote **timely learning** where risks are current.
- Reduce the burden on practitioners and families.
- Allow SABs to **triage**: using rapid learning to determine if a full SAR is still required.
- Demonstrate efficient, transparent decision-making.

SCIE's RiRT model fits well within the overarching principle of **choosing the right review for the right situation**.

As a summary - There is **no single prescribed method** for conducting a SAR.

The **local SAB must determine** the most appropriate methodology based on the review's complexity, context, and learning goals. Cumbria's SAR Methodology Toolkit exemplifies how local innovation can support national consistency, offering a flexible, person-centred, and learning-focused approach that aligns with statutory expectations and promotes systemic improvement.

17. Voice of Frontline Practitioners, Managers and Senior Leaders in SARs

[SCIE, Quality Markers 10: Practitioners' involvement]

Involving frontline practitioners, operational managers, and senior leaders throughout the SAR process is essential for generating grounded, meaningful learning and driving systemic change. Each level of the system brings a distinct perspective: frontline practitioners offer direct insight into the adult's lived experience and day-to-day practice challenges; operational managers provide context around workload pressures, resources, and decision-making; and senior leaders contribute strategic oversight and the authority to implement and sustain change.
Together, these perspectives ensure that learning is comprehensive, relevant, and actionable across the whole system.

17.1 The Critical Role of the Frontline Practitioners

A core principle of effective SARs is developing a clear understanding of what it was like for everyone involved with the adult. Hearing directly from frontline practitioners is crucial, as their reflections illuminate the adult's experience, expose systemic issues not obvious from records, and support practical, evidence-based recommendations that are grounded in real-world practice. Embedding their voice in the review is both respectful and essential for producing realistic and meaningful improvements.

Creating a Safe, Trusted, and No-Blame Environment

The Care and Support Statutory Guidance (para 14.169) emphasises that reviews must be safe and trusted experiences that promote honesty, transparency, and meaningful participation. Practitioners need confidence that the process is learning-focused rather than blame-oriented. SABs therefore have a responsibility to create conditions that support open dialogue through reflective interviews, learning events, and other structured opportunities for practitioner contribution.

17.2 Why Practitioner Involvement Strengthens Learning

Frontline engagement enhances SARs by:

- providing grounded insight into missed opportunities and decision-making contexts.
- promoting reflective practice and professional development.
- building trust, accountability, and transparency across the workforce.
- supporting the implementation and embedding of learning, as practitioners are more likely to drive and champion change when actively involved.

17.3 Looking Forward: Learning from Current Practice

In addition to reviewing past events, SARs benefit from exploring what currently works well and what challenges persist in similar situations. Engaging practitioners, managers, and leaders in reflective discussions about contemporary safeguarding practice helps identify systemic strengths and gaps, shaping recommendations that are both forward-looking and realistic.

18. Managing Disagreement and Escalation

Disagreement during a SAR—whether about scope, methodology, findings, or recommendations—should be approached constructively and with transparency. Differing professional and family perspectives are not uncommon and often reflect the complexity of safeguarding work. When dissent arises, it should be acknowledged and managed through open dialogue and facilitated discussion within the SAR Review

Group. The Chair for the Review Group plays a pivotal role in ensuring all voices are heard and that differing views are explored respectfully.

If consensus cannot be reached, the panel should consider practical steps such as revisiting the terms of reference, seeking additional evidence, or involving an independent facilitator. Where disagreement persists, it is acceptable to document dissenting views within the SAR report to maintain transparency and integrity. In line with governance protocols, unresolved matters should be escalated to the Independent Chair of the SAB, who holds final decision-making authority.

Potential resolutions may include seeking legal advice, involving an independent mediator, or clarifying evidence. The overarching aim must always be to maintain a focus on learning, improvement, and respectful collaboration.

There may also be occasions when disagreement occurs between the Independent Reviewer and panel members, including statutory partners or key stakeholders. These situations should be handled with professionalism, openness, and a commitment to safeguarding learning.

Local SABs should be encouraged to implement an internal escalation process to support the timely and effective resolution of professional disagreements when managing SARs.

The Independent Reviewer is commissioned for their subject matter expertise and professional experience; they are expected to offer confident, evidence-informed views while remaining open to other perspectives and engaging respectfully with differing opinions.

It is important to recognise that disagreement can arise at any stage of the process—from initial decisions on whether criteria have been met through to the final sign-off of the report. Initial efforts should focus on respectful dialogue, clarifying perspectives, and revisiting the evidence base to seek consensus. Where disagreement persists, escalation should follow a clearly defined process documented in the local SAR protocol/policy, including timelines, decision-making authority, and options for external advice if required.

Crucially, the independence of the review must be protected, and any resolution should prioritise the integrity of findings and the value of learning over organisational defensiveness or reputational concerns.

Final Decision-Making

Where disagreement between the Independent Reviewer and panel members cannot be resolved through discussion or escalation within the SAR subgroup, the matter should be referred to the Chair of the local SAB. Although the Care Act 2014 places statutory responsibility for SARs on the **SAB as a whole**, Chairs commonly provide the

final decision-making steer within local governance arrangements. In doing so, the Chair must ensure that the review remains independent, evidence-informed, and aligned with the statutory purpose of promoting learning and improving safeguarding practice. The Chair should consider all perspectives, seek further advice where needed, and make a determination that upholds transparency, integrity, and the best interests of adults at risk.

19. Quality of SAR reports

[SCIE, Quality Marker 13: The Report]

A high-quality SAR report is clear, concise, and focused on learning rather than blame. It should provide a balanced and evidence-informed analysis of events, highlight systemic issues, and make actionable recommendations that drive meaningful change across the local safeguarding system.

Reports must reflect the voice of the adult and their family, draw on multi-agency perspectives, and present findings in a way that is accessible to practitioners, leaders and decision-makers, while also being understandable and approachable for family members and the wider public.

The ultimate purpose of the report is to act as a catalyst for improvement, ensuring lessons are embedded across safeguarding practice and do not need to be repeatedly relearned.

Independent Reviewers play a critical role in ensuring that SARs build on existing knowledge rather than repeat past findings. Reviewers should actively examine previous SARs, regional and national learning, thematic reviews, and existing action plans. This ensures that recommendations are meaningful, proportionate, and genuinely add value. Duplication of learning and repetitive recommendations should be avoided; instead, Independent Reviewers should identify where existing actions are already underway, highlight barriers to implementation, and strengthen understanding of why previous learning may not have translated into practice change. This approach supports a more mature learning culture and helps the partnership focus on system improvements rather than generating new actions for their own sake.

In line with the Care Act 2014 and the Care and Support Statutory Guidance, a high-quality SAR should:

1. Meaningfully involve the adult (if alive) and their family or advocates throughout the review process.
2. Clearly define the scope and purpose of the review, reflecting the types of abuse or neglect relevant to the adult's circumstances.

3. Ensure independence, transparency, and objectivity, with reviewers who are skilled, impartial, and experienced.
4. Gather and analyse all relevant information, including inter-agency communication, decision-making, and contextual factors.
5. Provide a sound and well-reasoned analysis of what happened, why it happened, and what needs to change to prevent recurrence where possible.
6. Identify systemic learning, avoiding an over-focus on individual practice, and make recommendations that are SMART[2], actionable, and measurable.
7. Highlight examples of good practice to support balanced and constructive learning.
8. Promote accountability through learning, not blame, ensuring findings are disseminated and embedded across all relevant organisations.
9. Be written in plain English, with findings presented in a way that has practical value for frontline practitioners, leaders, and strategic partners.

The SCIE SAR Quality Markers provide a structured framework for assessing SAR quality, covering setup, governance, methodology, practitioner involvement, analysis, and impact.

A strong SAR also includes a clear, realistic action plan that the local SAB is responsible for delivering and overseeing, with follow-up and evaluation processes in place to ensure that identified learning results in measurable improvements.

Concerns about the quality of SARs conducted by Independent Reviewers should be addressed through robust commissioning processes, clear oversight, and effective quality assurance. This includes ensuring reviewers have the right expertise, that review methodologies are proportionate and transparent, and that learning is connected to wider partnership priorities rather than operating in isolation.

20. Questions versus Recommendations?

[SCIE, Quality Marker 12: Analysis]

In recent years, some local SABs have moved away from producing traditional recommendations within SARs and instead adopted an approach that poses key questions to the Board. This shift reflects a growing recognition that complex safeguarding issues often require deeper reflection and collaborative problem-solving, rather than prescriptive actions. By framing learning as questions, SABs encourage ongoing dialogue, shared ownership, and adaptive responses that are better suited to addressing systemic challenges.

As local SABs differ in their approaches, some may favour to different approach to evidence learning like using questions, recommendation or considerations to guide the review, there is no prescribed way of doing it and these preferences can be discussed and specified local within the Terms of Reference to support clarity and consistency.

When Independent Reviewers ask **questions** of the Board, these are designed to explore ***why*** decisions were made, ***how*** systems operated, and ***what*** *factors influenced practice*. They aim to uncover underlying causes of missed opportunities or good practice, rather than simply describing events.

Recommendations, on the other hand, translate this learning into specific, actionable steps that strengthen safeguarding systems.

Together, these methods ensure that reviews move beyond narrative to drive systemic improvement, embedding lessons into policy, training, and inter-agency collaboration.

20.1 Recommendations

Purpose:
To provide clear, actionable guidance for change or improvement in safeguarding practice.

Characteristics:

- Directive and specific.
- Based on findings from the review.
- Intended to be implemented, monitored, and evaluated.

Good Practice Principles:
Recommendations should be:

- **SMART**[2] – Specific, Measurable, Achievable, Relevant, and Time-bound.
- **CLEAR**[2] – Learning-oriented, evidence-based, actionable, with named accountability and a defined timeframe for review.
- **Comprehensive** – Covering key domains of safeguarding practice, as used in the first and second national SAR analyses, namely:
    - **Direct practice** with adults at risk.
    - **Multi-agency working and collaboration.**
    - **Organisational support and culture.**
    - **Governance and leadership.**
    - **National policy and system-level context.**

[2] Buckley, H. and O'Nolan, C (2014) 'Child death reviews: developing CLEAR recommendations." Child Abuse Review, 23(2), 89-103

These principles reflect the findings of the **Second National SAR Analysis**[3], which emphasises the importance of well-structured recommendations that drive meaningful change across all levels of safeguarding systems.

Example:

"The SAB should ensure that partner agencies implement a consistent multi-agency escalation protocol for unresolved safeguarding concerns, supported by clear governance oversight and regular audit."

Outcome:
Leads to measurable actions, often included in a post-SAR action plan with timelines, named leads, and mechanisms for monitoring and evaluation.

Pro's	Con's
Clear and Actionable - Provides specific guidance for improvement, making it easier to implement.	**Might Be Too Prescriptive -**Can limit flexibility or fail to consider local context and capacity.
Supports Accountability -Can be tracked through action plans and progress reports.	**Overload -** Too many recommendations can dilute focus and hinder implementation.
Drives Change - Helps ensure that learning leads to tangible improvements in safeguarding practice.	
Structured Follow-Up - Easier to evaluate and audit outcomes.	

20.2 Questions

Purpose:
To prompt **reflection**, **discussion**, and **critical thinking** among the SABs and partner agencies.

Characteristics:

- Open-ended and exploratory.
- Encourage the SAB to consider **why** something happened or **how** systems can improve.
- Often used when the learning is complex or when the reviewer wants to avoid being overly prescriptive.

Example:

[3] Local Government Association (2024) Second national analysis of Safeguarding Adult Reviews: April 2019 – March 2023. London: Local Government Association.

"How does the SAB ensure that learning from previous SARs is embedded into frontline practice?"

Outcome:
May lead to internal reviews, discussions, or the development of action plans based on the SAB's interpretation.

Pro's	Con's
Encourages Reflection - Promotes deeper thinking and discussion among SAB members.	**Lack of Clarity -** Might be too open-ended, leading to uncertainty about what action is needed.
Supports Ownership of Learning - Allows SABs to interpret and apply insights in a way that fits their local context.	**Harder to Monitor -** Difficult to track progress or evaluate impact without converting questions into actions.
Flexible and Adaptive -Useful when the learning is complex or when prescriptive actions might not be appropriate.	**Risk of Inaction -** Without clear direction, questions might be acknowledged but not acted upon.
Promotes Dialogue - Can be used to stimulate learning events, workshops, or board discussions.	

Consideration for Best Practice:

Using learning questions alongside recommendations could strengthen the quality and impact of a SAR. While learning questions help frame the inquiry and guide analysis, recommendations translate that learning into practical, measurable change. When used together, they create a balanced approach that supports curiosity, critical reflection, and real-world improvement.

Consider combining **questions** and **recommendations** which allows SARs to:

- Encourage **critical thinking** and **ownership**.
- Provide **clear direction** for change.
- Foster a **learning culture** while ensuring **accountability**.

When to Use Each

- Use **questions** when you want to **stimulate learning** and **encourage ownership** of the issues.
- Use **recommendations** when you want to **drive specific change** and ensure **accountability**.

21. Policy, Practice and Learning: Evidence-informed SARs

SARs exist to identify learning and drive improvement in how agencies work together to safeguard adults with care and support needs, with the aim of preventing future deaths or serious harm. The Care Act 2014 places a duty on local SABs to arrange a SAR where the Section 44 criteria are met, and it also requires Board partners to cooperate with a view to identifying lessons and applying them to future practice.

Why an evidence base matters
SARs are strongest where they go beyond describing "what happened" and provide a robust analysis of "why it made sense at the time" and "what needs to change in the system." To support this, SAR Authors should routinely draw on relevant research, statutory guidance, and sector-led learning so that findings and recommendations are grounded in established evidence and reflect current good practice.

The second national analysis of SARs in England (covering reviews completed April 2019–March 2023) provides a significant evidence base about recurring features of safeguarding practice (including the prominence of self-neglect and overlapping needs) and identifies improvement priorities that SABs and SAR Authors can use as a benchmark for local learning.

Anchoring SARs in statutory and national guidance
Good practice is to ensure SAR analysis and recommendations are clearly informed by:

- **Care Act 2014, Section 44** duties and purpose (learning and application of learning).
- **Care and Support Statutory Guidance** (including safeguarding expectations and the status of self-neglect within adult safeguarding).
- **SCIE resources on SARs**, including the importance of maintaining a learning focus rather than apportioning blame, and approaches that strengthen the quality of review processes.
- **National SAR analyses and sector-led improvement resources** commissioned by LGA/ADASS, to support consistency and to test whether local findings align with wider learning.

Some key thematic areas can include:

1) **Self-neglect (including hoarding)**

Self-neglect is repeatedly identified within SARs and requires careful attention to engagement, risk management, mental capacity considerations, and multi-agency coordination over time. SAR Authors should reflect relevant evidence and practice tools on effective approaches to self-neglect, including relationship-based practice, understanding executive functioning, and the need for coherent local multi-agency pathways.

Useful evidence sources include SCIE self-neglect resources and LGA/Research in Practice materials linking Self-Neglect with Making Safeguarding Personal and learning from SARs.

2) **Co-occurring conditions (mental health and addiction)**

Many adults who feature in SARs experience co-occurring mental health and substance use, which can create barriers to service access, increase risk of exclusion from support, and require integrated, person-centred responses across systems. SAR Authors should consider relevant national guidance on how services should work together to avoid people being "passed between" mental health and substance use pathways.

Key national resources include NICE guidance on coexisting severe mental illness and substance use (service coordination and multi-agency care planning) and the DHSC/NHS England delivery framework setting out actions for better integrated care.

- Co-occurring mental health and substance use: delivery framework - GOV.UK
- Better care for people with co-occurring mental health, and alcohol and drug use conditions

3) **Inclusion health / multiple disadvantage (including homelessness where relevant)**

Where SARs involve people affected by severe social exclusion (for example homelessness, substance dependence, contact with the justice system, or vulnerable migration), it is good practice to use an **inclusion health lens** to understand how stigma, trauma, and service design can create barriers to engagement and exacerbate risk. NHS England's inclusion health framework provides a useful reference point for how systems can reduce inequalities and improve access, experience, and outcomes for inclusion health groups.

- Inclusion Health: applying All Our Health - GOV.UK

Where relevant, SAR Authors may also draw on evidence about mortality and risk among people experiencing homelessness, including the annual findings from the Museum of Homelessness Dying Homeless Project.

Example of targeted national guidance (where relevant)
From time to time, national correspondence and guidance may provide specific expectations for SABs on particular themes. For example, a joint ministerial letter (May 2024) set out recommendations for SABs regarding individuals rough sleeping, including strengthening partnership working and using review processes to promote learning and improvement.

- Working across housing, social care and safeguarding to tackle long-term rough sleeping: webinar - GOV.UK

Translating evidence into stronger SAR outputs
To ensure research and guidance genuinely improve SAR quality (rather than sitting as background reading), SAR Authors should evidence how literature has been used to:

- **inform the lines of enquiry** and test assumptions about practice and engagement;
- **contextualise decision-making**, including legal literacy, threshold decisions, and multi-agency coordination;
- **strengthen findings and recommendations**, aligning them to known "what works" and improvement priorities;
- support recommendations that are **specific, measurable and embedded in governance**, so learning leads to sustained change.

Evidence-informed SARs require careful, respectful and non-stigmatising language. Stigma and discrimination are recurrent experiences for many adults who appear in SARs, particularly those facing social exclusion such as homelessness, substance dependence, or long-term mental and physical health difficulties. Language used in

SARs can unintentionally reinforce "blame" narratives and obscure the wider systemic factors that shaped what happened. To support thoughtful, person-centred analysis, SAR Authors should ensure that language choices accurately reflect people's experiences, avoid assumptions, and clearly highlight the influence of services, thresholds and decision-making processes. This should also include consideration of local and national political decisions and factors—such as resourcing, policy directions and relevant legislation—that may have impacted practice and outcomes.

When describing people experiencing homelessness—a highly stigmatised and socially isolating experience—it is particularly important to avoid reproducing dominant narratives that frame individuals as responsible for the harms they experience. SAR Authors should therefore:

- Use person-first, non-labelling language, such as "people experiencing homelessness" or "someone who is rough sleeping", rather than collective terms like "the homeless" or labels such as "rough sleeper".
- Avoid simplistic or judgemental explanations such as "lifestyle choice", and instead explore the evidence-based reasons behind decisions, including trauma, fear, lack of safety, previous service experiences or unavailable suitable options.
- Avoid terms like "non-engaging", which locate the problem within the person. More accurate alternatives include "difficulties meeting the expectations of professionals", "engagement that was not working", or "services were unable to engage with him/her/them."

- Ensure that analysis considers how services, thresholds, policies, and expectations shaped what was possible, rather than implying blame or individual failure.

Applying respectful and precise language supports SARs to produce learning that is fair, accurate and trauma-informed. It also enables a clearer focus on systemic factors, multi-agency responsibilities and opportunities for improvement—reinforcing the core purpose of SARs: to understand, to learn, and to support change that reduces risk for others in the future.

Driving Systemic Change

To move from learning to action, SARs can identify opportunities for the SAB to strengthen policy and practice:

- **Evidence the impact** of SAR recommendations on practice and outcomes.
- **Monitor implementation** through robust governance and performance frameworks.
- **Share learning** locally, regionally, and nationally to prevent recurrence and improve safeguarding for people experiencing homelessness.

22. Actions and Action Plans

SARs provide vital opportunities to reflect on practice, identify systemic challenges, and embed learning that improves outcomes for adults at risk. However, learning alone does not lead to change—implementation is key. This section sets out the action plans designed to translate recommendations into practical steps that drive improvement across agencies. Each action is aligned with the findings of the SAR, ensuring that lessons learned are not only acknowledged but actively applied to strengthen safeguarding arrangements, enhance multi-agency collaboration, and prevent recurrence of similar issues.

The plans outlined here focus on:

- **Clear accountability** for delivery and monitoring.
- **Measurable outcomes** to evidence impact.
- **Shared ownership** across partners to embed learning into everyday practice.

By committing to these actions, we aim to move beyond reflection to tangible, sustainable change that protects and empowers adults in our communities.

SMART actions refer to a framework used to set clear, achievable goals or tasks, particularly in planning, performance management, and safeguarding contexts. The acronym stands for:

- **S**pecific – The action should be clearly defined and focused, leaving no room for ambiguity.
- **M**easurable – There should be a way to assess whether the action has been completed or progress has been made.
- **A**chievable – The action must be realistic and attainable given the resources and constraints.
- **R**elevant – It should directly relate to the overall goal or safeguarding concern.
- **T**ime-bound – The action should have a clear deadline or timeframe for completion.

In SARs, SMART[2] actions help ensure that recommendations are practical, accountable, and lead to meaningful improvements in practice.

Here's an example of a **SMART action** in a safeguarding adults context:

Action: The local care provider will implement a mandatory training session on recognising signs of self-neglect for all frontline staff.

- **Specific**: The action targets training on self-neglect for frontline staff.
- **Measurable**: Completion will be tracked through attendance records and post-training evaluations.
- **Achievable**: The provider has access to training resources and facilitators.
- **Relevant**: Addresses a key learning point from a recent SAR where signs of self-neglect were missed.
- **Time-bound**: Training to be completed by a specified date.

"They have kept in contact, which is positive. However, the process of change is slow and that does not feel reassuring even though recommendations are going ahead."
(Family Member)

22.1 Top Tips for Sharing, Tracking and Embedding Learning from SARs

Create a Central Learning Log	• Maintain a live, accessible log of all SAR recommendations and actions. • Include responsible leads, deadlines, evidence of progress, and assurance statements. • Track cross-cutting themes across multiple SARs to identify systemic patterns (for example: professional curiosity, information sharing, risk escalation). • Use the log as a *whole-system learning repository* rather than just an action tracker.

Translate Learning into Action	• Convert findings into SMART actions (Specific, Measurable, Achievable, Relevant, Time-bound).
	• Ensure actions are realistic, resourced, and clearly owned by agencies or multi-agency groups.
	• Build in *"evidence of change" requirements* from the outset — for example:
	  ○ What data will show improvement?
	  ○ How will practitioners describe the impact on their day-to-day work?
	  ○ What will you expect to see in future case audits?

Use Multi-Agency Learning Events	• Host reflective learning sessions with frontline staff, managers and leadership. • Consider alterative methods to share the learning like short video's can be used for wider dissemination. • Encourage open, non-judgemental discussion of SAR findings and what they mean for real practice. • Use structured models (such as Appreciative Inquiry, Learning Conversations or After-Action Reviews) to document themes and actions that emerge. • Capture the *cultural indicators* — confidence, communication, understanding of thresholds, shared risk language.
Integrate into Governance Structures	• Embed SAR learning into SAB subgroups, quality assurance frameworks, workforce development plans, and audit tools. • Ensure learning appears consistently across agendas so that it becomes *business as usual*. • Provide regular, transparent progress reports to the local SABs, noting both achievements and barriers. • Use a "You said, we did, what changed" format for clear systemic oversight.

Monitor Implementation and Impact	• Use audits, surveys, reflective sessions, supervision dip-samples and case file reviews to assess whether practice has actually changed.
	• Ask agencies to evidence:
	  ○ *Practice impact* (What are staff doing differently?)
	  ○ *System changes* (What has been strengthened— processes, pathways, partnerships?)
	  ○ *Cultural indicators* (Is there improved trust, escalation, joint working?)
	• Always ask: "What's different now for adults at risk?"

Share Learning Widely	• Disseminate key messages through:
	  ○ Briefings
	  ○ Newsletters

	○ Infographics and visual summaries ○ Podcasts or videos ○ Multi-agency forums and leadership updates • Tailor messages for different audiences (for example practitioners, senior leaders, elected members, partners, the public). • Document *how* learning has been shared and *what feedback you received*.
Link with Other Review Processes	• Cross-reference learning from: ○ Domestic Abuse Related Death Reviews (DARDR) ○ LeDeR reviews ○ Child Safeguarding Practice Reviews (CSPR) ○ Serious Incident and Patient Safety reviews • Identify common themes, systemic risks, and potential joint workforce development programmes. • Ensure duplication is avoided and learning is connected across systems.
Make Learning Personal	• Use anonymised feedback from adults, families and carers to illustrate the human impact of SAR findings. • Encourage practitioners to reflect on: ○ What the SAR findings mean for their role ○ What they would change as a result ○ What gets in the way • Build space for reflective supervision and professional curiosity discussions.
Use Data to Drive Learning	• Monitor changes in safeguarding concerns, referrals, themes, and outcomes over time. • Triangulate quantitative data with qualitative learning from practitioners and adults at risk. • Use this to identify: ○ Areas where learning has embedded well ○ Areas where cultural or process barriers remain ○ Emerging risks requiring proactive action
Celebrate Improvements	• Highlight where SAR learning has driven positive systemic or cultural shifts. • Share examples of improved practice, partnership working, and person-centred approaches. • Recognise teams and individuals who have contributed to meaningful change — reinforcing a culture of continuous learning.
Document Systemic Impact	Track System-Level Change

and Cultural Shift (New Section)	• Document changes to processes, pathways, and joint working arrangements that have resulted directly from SAR learning.
	• Capture systemic improvements such as:
	  ○ Better multi-agency escalation procedures
	  ○ More consistent risk assessments
	  ○ Improved information-sharing protocols
	  ○ Strengthened commissioning and oversight arrangements
	Evidence Cultural Change
	• Measure soft indicators of culture, such as:
	  ○ Increases in professional curiosity
	  ○ More confident challenge across agencies
	  ○ Stronger reflective practice
	  ○ Improved trust and communication between partners
	• Use staff surveys, focus groups, and supervision feedback to show where culture is shifting — and where it still needs attention.
	Create a "Learning Line of Sight"
	• Map how SAR learning moves from: Finding → Recommendation → Action → Implementation → Impact → Improved outcomes
	• Document this clearly so that Boards can trace change and assurance partners can see tangible results.
	Regular Systemic Reviews
	• Build in periodic "learning impact reviews" to revisit themes 6–12 months after actions close.
	• Assess whether improvements have been sustained or whether drift has occurred.
	• Use these reviews to understand *whole-system maturity* and readiness for continuous learning.

23. Governance Overview: Acceptance and sign off of a SAR

[SCIE, Quality Marker 6: Governance]

SABs must operate a structured governance process to ensure SAR reports and recommendations are rigorously reviewed, formally accepted, and acted upon. This process should be transparent, person-centred, and compliant with statutory guidance under the Care Act 2014. A typical governance pathway includes:

1. Draft Report Review

- The Independent Reviewer shares the draft SAR report with the SAR Review Group, panel members, and relevant stakeholders.
- Agencies involved in the review provide factual accuracy feedback and comment on recommendations.
- Feedback should be collated systematically, with clear deadlines and a process for resolving discrepancies.

2. Quality Assurance

- The SAR Review Group assesses the report for:
  - **Clarity and fairness** – ensuring findings are evidence-based and balanced.
  - **Alignment with terms of reference** – confirming scope and objectives are met.
- Legal and safeguarding leads may be consulted to ensure compliance with legislation, confidentiality, and risk management.
- Each agency confirms that internal governance checks have been completed before sign-off.

"It was a difficult read, quite sad read, reading something in black and white could be quite traumatic, almost like watching a film for the second time, I knew the storyline quite well, for some families who don't know the full storyline, reading the report might be much more harrowing."

(Family Member)

3. Voice of the Adult

- Best practice is to involve the adult and/or their representative before finalisation:
  - Share the draft report with sufficient time for reflection and feedback.
  - Invite for them to write a personal statement or reflection, written in their own words.
  - Include their contribution in the final report where appropriate.
- Engagement should be sensitive, transparent, and aligned with **Making Safeguarding Personal** principles.
- Consider alternative formats (plain English summary, visual aids, audio) to ensure understanding of:
  - Key learning and why it matters.
  - Evidence behind conclusions.
  - Decisions made during the review.
  - Planned changes as a result.

This strengthens legitimacy, emotional intelligence, and person-centred focus.

"Although it is difficult to read, it has helped that our concerns have been listened to."

(Family Member)

"I think if you leave someone alone to read it, it actually helps…You can feel a bit overwhelmed… you need a bit of time to process."

(Family Member)

4. Formal Presentation to the SAB

- The final report and the findings of the review will be presented to the SAB.
- The Board discusses:
  - Relevance and feasibility of recommendations
  - Potential impact on safeguarding practice
  - Resource implications and implementation challenges.

5. Decision and Sign-Off

- The SAB formally accepts the report and recommendations through a recorded decision-making process (e.g., vote or consensus).
- Any dissent or reservations are documented, with agreed actions to address concerns.
- Where significant disagreement remains unresolved, escalate to the Chair or an appropriate governance forum (see Section 18. Managing Disagreement and Escalation')

6. Publication and Dissemination

- Reports should be published in a timely and accessible manner, subject to confidentiality and safety considerations (see Section 'Publication of SARs').
- Statutory guidance encourages publication to promote transparency and share learning widely.
- Good practice includes:
  - Executive summary or "7-minute briefing" in plain English
  - Inclusion of a family statement where appropriate.
- Learning should be disseminated locally, regionally, and nationally.
- If full publication is unsafe or inappropriate, consider alternatives such as:
  - Redacted version
  - Executive summary
  - Learning briefing (see Section 22).
- Make arrangements for the published document to be added to the National Library and share any regional or national learning at the relevant networks.

7. Action Planning and Monitoring

- Develop a multi-agency action plan with clear responsibilities, timelines, and success measures.
- The SAB monitors implementation through regular progress reports and evaluates impact on safeguarding practice.

Ownership of the SAR Report
Under the Care Act 2014, the SAB is accountable for commissioning and overseeing SARs.

While the term "owner" is not used explicitly, the SAB:

- Commissions the SAR and ensures statutory criteria are met.
- Appoints the Independent Reviewer to produce the report.
- Retains responsibility for approval, publication, and dissemination.
- Ensures the report reflects multi-agency learning, is person-centred, and promotes transparency.
- Decides how and when the report is published and what actions follow.

In practice, the SAB is considered the "owner" of the SAR report.

24. Why SARs Are Expected to Be Published on the Local SAB's website and Why It Matters

[SCIE, Quality Marker 14: Publication and Dissemination]

SARs are a vital mechanism for strengthening practice and improving outcomes across agencies. The (Care and Support Statutory Guidance, para 14.179) sets a clear expectation that SARs should be published unless there is a compelling reason not to, supporting transparency, accountability and the shared learning needed to prevent future harm.

In some reviews, publication may carry a risk of identifying the adult, their family or others involved. Where this risk cannot be managed through standard anonymisation, it may be appropriate to redact all references to the commissioning SAB. This approach enables the review to be included in the National SAR Library, ensuring that learning is still shared nationally while reducing the likelihood of local identification.

Publishing a redacted version preserves the core purpose of the SAR: promoting system-wide learning and improvement, while upholding necessary safeguards for privacy and anonymity. This maintains the balance between openness and protection, and ensures that valuable insights continue to inform national practice development.

Publishing SARs helps to:

- **Disseminate learning widely:** Making findings publicly accessible supports consistent improvement across health, social care and community services.
- **Maintain public confidence:** Transparent publication demonstrates that safeguarding partners take serious incidents seriously and are committed to improvement.

- **Drive systemic change:** Openly shared learning helps strengthen multi-agency collaboration and encourages better practice across organisational boundaries.

However, in exceptional circumstances—such as risks to privacy, potential distress to families, or ongoing legal processes—full publication may not be appropriate. In these reviews, the rationale should be clearly recorded, and learning should still be shared through internal or redacted mechanisms.

Ultimately, publication of SARs reflects a commitment to a culture of learning rather than blame. This approach ensures that safeguarding systems continue to evolve and that adults with care and support needs receive safer, more effective support.

24.1 When to publish a SAR

Publishing a SAR is encouraged where it strengthens transparency, accountability, and meaningful learning across the safeguarding partnership. Decisions about publication should be considered from the outset and referenced in the Terms of Reference (ToR). This enables early clarity on the most appropriate publication format. The ToR may outline whether:

- **A learning-focused SAR report** will be published, highlighting systemic findings, themes, and multi-agency improvements without centring on personal narrative; or
- **A personalised SAR report** will be published, offering richer insight into the adult's life and experiences while maintaining respectful anonymisation.

> "We were consulted about what name to use for our son/brother. Significant media interest helped us here (the given name was used)"
> (Family Member)

Publication decisions should remain under review throughout the SAR process, as new information may reasonably influence the final decision.

A SAR should be considered for publication when:

- **There is significant public interest**, including high-profile reviews or where serious or systemic practice issues have been identified.
- **The learning has wider value**, benefiting agencies beyond the local area and contributing to regional or national safeguarding practice.

- **The adult or their family consents**, or—where consent is withheld—publication is still judged to be in the wider public interest. **The report can be sufficiently anonymised**, protecting individuals' identities and safety.
- **Robust quality assurance has taken place**, demonstrating clarity, fairness, proportionality, and accuracy.
- **There are no legal or safety barriers**, including ongoing criminal or coronial proceedings or risks of harm or identification.
- The SAB should **identify any parallel processes** that may impact publication; for example, a joint DARDR/SAR cannot be published until Home Office governance is completed and the final report has been formally signed off.

Engagement with Adults and Families About Publication

It is essential that the adult (where alive), or their family, are meaningfully engaged throughout the review regarding how publication will be managed. This is particularly important in **high-profile reviews**, or where **media interest is anticipated**, as families may experience distress, uncertainty, or increased scrutiny. Ongoing dialogue helps to:

- prepare families for potential public and media attention;
- clarify what information will be shared, how anonymisation will be applied, and what this means in practice;
- ensure their views are considered when shaping publication decisions;
- uphold transparency, humanity, and respect within the review process.

Proactive communication supports trust, helps families feel informed and involved, and aligns with Making Safeguarding Personal principles—ensuring the SAR process is not only procedurally sound but also compassionate and ethically grounded.

"I'm happy for the report to be published otherwise… how's everybody else going to know that… these lessons can be learned."

(Family Member)

24.2 When NOT to publish a SAR

There are situations where publishing a full SAR report may not be appropriate. Non-publication should always be based on a clear, evidence-informed rationale,

particularly where there are risks of harm, legal constraints, or unresolved aspects of the review. It may be necessary **not** to publish when:

- **There is a risk of harm** to the adult or family members — including emotional distress, re-traumatisation, or threats to physical safety.
- **Legal proceedings are ongoing**, and publication could prejudice criminal, coronial, or regulatory processes.
- **Confidentiality cannot be assured**, even with anonymisation or redaction.
- **The adult or family strongly objects**, and there is no overriding public interest requiring publication.
- **The review findings remain incomplete or contested**, meaning publication would be misleading or unfair.

Where full publication is not possible, SABs should still ensure that the learning is shared. Producing a **learning-focused summary or briefing document** is good practice, enabling key themes, findings, and recommendations to be disseminated effectively without exposing sensitive details.

Sharing Learning When Full Publication Is Not Appropriate

Not publishing—or delaying clarity about publication—can lead to perceptions of secrecy or avoidance. However, full publication may not always be safe, ethical, or proportionate. SABs must balance:

- The duty to promote **learning and accountability.**
- The rights, wishes, and wellbeing of the **adult and family.**
- **Legal obligations**, including the Care Act and data protection legislation.
- The potential impact on **professionals and services** involved.

At the point the SAR is signed off, the SAB should document the rationale for non-publication and clearly state how learning will instead be shared.

A **Learning Report** or **Learning Brief** is often the most effective alternative. This allows key learning to be disseminated widely while minimising the risk of harm or re-identification. Unlike an executive summary—which may appear selective or incomplete—a Learning Report provides transparency about what has been learned, without disclosing sensitive narrative detail.

Recommended Approaches When Full Publication Is Not Possible

1. Produce a Learning Summary or Briefing Document

- Provide an anonymised summary that excludes sensitive details.
- Focus on systemic findings, themes, and recommendations.
- Clearly explain why the full SAR is not being published.

2. Internal Dissemination Across the Partnership

- Share learning through multi-agency briefings, internal newsletters, and safeguarding forums.
- Ensure practitioners understand the relevance to their roles.

3. Facilitate Learning Events

- Use anonymised case studies to explore themes.
- Host multi-agency workshops to deepen understanding and support reflection.

4. Embed Learning Into Practice

- Update local policies, procedures, and supervision frameworks.
- Incorporate learning into training, induction, and Continuing Professional Development (CPD) activities.

5. Monitor and Review Impact

- Develop a multi-agency action plan and track progress through SAB oversight.
- Review implementation regularly to ensure learning is sustained.

24.3 Publication When the Adult Is Still Alive

When the adult at the centre of the SAR is alive, decisions about publication must be handled with enhanced care, sensitivity, and transparency. The local SAB must ensure that the adult's rights, wishes, privacy, and safety are central to the process, while also fulfilling its statutory duty to promote learning and improve safeguarding practice.

Below are best-practice considerations for the four most common scenarios.

1. When the Adult has engaged and consents to publication

- **Confirm and record informed consent -** Ensure the adult understands the purpose of publication, what will be shared, potential media interest, and their right to withdraw consent before publication. Keep a clear written record.
- **Apply proportionate anonymisation -** Even with consent, consider redacting or anonymising sensitive details to protect the adult's privacy, safety, and dignity—particularly if the review is high-profile or identifiable.
- **Offer ongoing communication and support -** Share likely timelines, publication format (learning-focused vs personalised), and any planned communications. Provide a named contact and access to support (e.g., advocacy) before, during, and after publication.
- **Reflect the adult's voice respectfully -** Where appropriate, include the adult's perspective on their experiences and on the learning, ensuring language is accurate, compassionate, and non-stigmatizing.

- **Check legal and safety considerations -** Confirm there are no active legal constraints (e.g., criminal or coronial proceedings) or risks of harm arising from publication. If risks exist, adjust the approach (timing, redaction, or format).
- **Maintain the learning focus -** Keep the report centred on systemic findings and practical recommendations; avoid blame, and ensure learning is disseminated across the partnership with a clear plan for implementation.
- **Document the decision-making -** Record the SAB's rationale, the consent process, risk assessment, and the safeguards applied, to demonstrate transparency and accountability.

2. When the Adult Has Engaged but Does Not Consent to Publication

- The adult's views should be listened to, respected, and clearly recorded.
- Lack of consent does **not automatically prohibit publication**, especially where there is a strong public interest or significant system learning; however, the SAB must weigh this carefully.
- If publication proceeds, the rationale must be documented, and the adult should be informed of the decision, the reasons, and the measures taken to protect their identity.
- Additional anonymisation, redaction, or use of a learning-focused (non-narrative) report may be necessary to safeguard the adult's privacy and wellbeing.

3. When the Adult Is Alive but Has Chosen Not to Engage in the Review

- The adult's decision not to take part must be respected, recorded, and revisited at appropriate points (in case their position changes).
- Non-engagement does **not prevent** publication if doing so supports transparency, accountability, or wider learning.
- Clear, accessible information about the SAR process, including possible publication, should still be provided to the adult, even if they do not wish to be involved.
- If appropriate, the adult may still be offered the opportunity to comment on a draft or on findings affecting them.
- Any published report must be written in a way that protects the adult's dignity and identity.

4. When the Adult Consents to Publication but Is Not Actively Engaged

- Consent to publication should be confirmed, recorded, and revisited if necessary.
- Even if the adult does not actively participate, their consent indicates openness to sharing learning.
- The SAB should still consider whether sensitive details require anonymisation or partial redaction to prevent unintended harm.
- Where possible, the adult should be informed about likely timescales, publication format, and any anticipated media interest.

Cross-Cutting Principles for All Scenarios

Balancing Transparency and Privacy

Publication should always prioritise the adult's safety, dignity, and rights.

Reports must be drafted with careful anonymisation and consideration of proportionality.

Purpose of Publication

The aim is to share learning that improves safeguarding practice, not to expose personal histories or allocate blame.

Decision-Making and Accountability

The SAB is responsible for the final decision regarding publication.

Rationale must be clearly recorded, demonstrating a balanced consideration of the adult's wishes, public interest, and safeguarding learning.

Communication and Support

Adults (and families where appropriate) should receive timely, clear communication about publication decisions and what they mean in practice.

This is especially important where publication might attract media attention or cause distress.

24.4 Publication of SARs and Managing Coroner's Inquests

When a coroner's inquest is pending, the publication of a SAR must be approached with care to avoid prejudicing the inquest or causing undue distress to bereaved families.

Key Principles and Guidance

1. Legal Position

- There is **no statutory prohibition** under the Care Act 2014 preventing publication of a SAR prior to an inquest.
- However, **best practice recommends caution** and proactive engagement with the coroner to ensure publication does not interfere with coronial proceedings.

Recommended Actions:

- Maintain **close liaison between the local SAB and the coroner** to agree timing and approach.
- Consider delaying publication if the SAR contains material that could overlap with or influence the inquest.
- Develop a **joint communication plan** to manage family expectations and uphold transparency without compromising legal processes.

2. Chief Coroner's Guidance

- While not prohibiting SAR publication, the guidance stresses the importance of preserving the integrity of the inquest and avoiding external influence.

3. Government Guide to Coroner Services

- Emphasises that bereaved families should be **kept informed and involved** in decisions that may affect them, including SAR publication.

Summary
Publishing a SAR before an inquest is legally permissible but should be carefully considered in consultation with the coroner. The SAB must balance the benefits of timely learning and transparency against the risk of prejudicing proceedings, while ensuring families are supported throughout.

Please refer to National SAB Guidance on the Interface between SARs and Coronial Processes for further information about best practice between SARs and Coronial Inquests.

25. Organisational Memory in SARs – why this matters?

Retaining organisational memory ensures that learning from SARs leads to **sustained improvement** rather than short-term fixes. With a structured approach to capturing, storing, and using SAR learning, organisations avoid losing insight through staff turnover or leadership changes, maintain **continuity of practice**, and keep previous recommendations **alive in decision-making and service delivery**.

What effective organisational memory achieves:

- **Prevents repeat mistakes** by surfacing recurring themes and systemic issues.
- **Drives continuous improvement** through informed updates to policies, training, supervision, and practice.

- **Enables strategic oversight** so SABs can track trends, allocate resources, and set priorities based on evidence.
- **Strengthens accountability and transparency** by recording actions taken and progress against recommendations.
- **Facilitates cross-agency learning**, aligning partners around shared insights and reducing siloed responses.

How to build and sustain it:

- **Create a SAR Learning Repository:** A central, searchable archive of reports, thematic findings, actions, and impact updates.
- **Use Thematic Analysis routinely:** Aggregate learning across cases to identify patterns, emerging risks, and priority areas.
- **Embed learning in workforce development:** Integrate key SAR insights into induction, CPD, team briefings, and supervision.
- **Link learning to Quality Assurance:** Use SAR themes to inform audits, practice observation, and performance reviews.
- **Review and refresh regularly:** Revisit past SARs to assess progress, retire actions that are complete, and update areas needing further work.

Tip: Assign clear ownership (who updates the repository, who leads thematic reviews, who reports impact to the SAB) and set a light-touch cadence (e.g., quarterly thematic review; six-monthly impact report) to keep organisational memory active and useful.

26. Identifying, Sharing, and Embedding Learning from SARs

Identifying learning and themes in SARs is essential for revealing systemic issues, practice gaps, and areas for improvement across the safeguarding partnership. Examining patterns—such as professional curiosity, multi-agency risk management, communication, and legal literacy—enables the development of focused actions that strengthen collaboration, prevent harm, and improve outcomes for adults at risk.

However, a SAR only achieves its purpose when learning is actively shared, understood, and embedded. Insights must be communicated beyond the written report and translated into everyday practice across the entire system: statutory partners, commissioned providers, voluntary and community organisations, and the broader market management landscape. Reaching all parts of the workforce and care market helps build a consistent, informed, and preventative safeguarding culture.

Sharing learning is also an act of respect and legacy. Families place significant trust in the SAR process and often see it as an opportunity for their loved one's experience to improve safeguarding for others. Keeping families appropriately updated on emerging themes and resulting improvements honours their contribution and reflects the value placed on their loved one's life.

Sharing Learning Locally

Local dissemination of SAR learning:

- Strengthens transparency, accountability, and trust in the SAB.
- Supports practitioners, managers, and providers to reflect on and improve their practice.
- Enhances multi-agency coordination and encourages consistent responses to safeguarding concerns.
- Informs commissioning and market oversight, helping identify risks, quality issues, and opportunities for improvement across providers.

Sharing Learning Regionally

A regional approach:

- Enables learning where reviews span organisational boundaries or provider footprints.
- Promotes consistency in safeguarding expectations and standards across neighbouring areas.
- Allows regional networks to identify recurring themes or pressures and co-develop joint resources, training, and solutions.

Sharing Learning Nationally

National sharing:

- Contributes to the National SAR Library and wider sector learning.
- Informs national policy, training, and professional standards.
- Supports early identification of emerging or recurring safeguarding themes requiring coordinated national action.

Escalating Emerging Risks Nationally

Some SAR findings have implications that extend beyond local boundaries. Issues such as commissioning challenges, gaps within local pathways, or cross-agency communication difficulties may also reflect patterns seen at a national level.

In addition, SAR Authors should consider how gaps in legislation, national resourcing pressures, and wider system-level factors may have influenced practice, shaped decision-making, or limited the options available to practitioners and services.

Where local systems cannot resolve risks, or where concerns have wider significance, SABs can use the National Escalation Protocol for Issues from SARs (LGA, 2025) to:

- Ensure significant or recurring risks receive regional or national attention.
- Alert regulators, national bodies, and policy organisations to emerging patterns.
- Influence national standards, commissioning frameworks, and workforce development.
- Reduce the likelihood of similar harms occurring elsewhere.
- Using the escalation protocol strengthens accountability and ensures learning from one area contributes to safer practice nationally.

Emphasising the Impact of Change

The value of a SAR lies not only in identifying what happened but in demonstrating how learning leads to meaningful, measurable, and lasting change. Impact must be visible through strengthened procedures, improved pathways, better-informed practice, and more confident multi-agency working.

Families are central to this understanding. Being able to show what has changed and how risks to others have been reduced provides reassurance and creates a lasting legacy for the adult whose experience shaped the learning.

Key elements of demonstrating impact:

- **Practice improvement:** Better professional curiosity, risk assessment, and decision-making.
- **Cultural change:** More open, reflective, learning-focused environments.
- **Systemic change:** Strengthened pathways, governance, and partnership working.
- **Market-wide learning:** Provider services embedding learning into training and quality assurance.
- **Sustained outcomes:** Evidence through audits, supervision, and data trends.
- **Family reassurance**: Transparent communication about improvements.

Implementing Learning from SARs

Implementing learning is the point at which reflection becomes action. It requires leadership, shared accountability, and coordinated effort across the whole safeguarding system, including the wider provider market.

Families have a vital stake in this process, and keeping them informed helps reinforce the purpose of the review and the value placed on their loved one's experience.

Key components of effective implementation:

1. Clear, actionable recommendation/actions

- Specific, measurable, achievable, and time-bound.
- Clear accountability and ownership.
- Defined measures for monitoring impact.

2. Shared ownership and accountability

- Multi-agency action plans coordinated through SAB subgroups.
- Senior leadership oversight to maintain pace and visibility.
- Regular reporting, challenge, and escalation where needed.

3. Embedding learning into systems and practice

- Updated policies, procedures, and pathways.
- Integration into training, supervision, and workforce development.
- Changes to commissioning, contracting, and provider monitoring.
- Strengthened interagency communication and risk management.

4. Strengthening the provider and market landscape

- Dissemination of learning to all commissioned, regulated, and voluntary services.
- Provider-led action plans and reflective learning processes.
- Integration into contract reviews, tenders, and quality assurance.
- Support for smaller or specialist providers to engage fully.

5. Monitoring progress and evidencing improvement

- Audits, dip samples, practice observations, and practitioner feedback.
- Evidence of practice and decision-making changes.
- Data showing reduction in recurring issues.
- Independent scrutiny as appropriate.

6. Building a culture of continuous learning

- Supportive, non-blaming environments that encourage honest reflection.
- Sharing improvements across agencies, regions, and sectors.

- Celebrating innovation and good practice.
- Ongoing cycles of audit, review, and learning.

Bringing It All Together

When SAR learning is clearly identified, meaningfully shared, confidently implemented, and rigorously monitored, it becomes a powerful catalyst for safeguarding improvement. This cycle strengthens practice, enhances collaboration, and reduces the likelihood of repeat failings. Above all, it honours the adult at the centre of the review by ensuring their experience leads to safer, more compassionate, and more effective safeguarding for others.

"All of us can learn from each other"
(Family Member)

26. Learning Events

A **Learning Event** is a facilitated session involving key stakeholders, managers, and practitioners designed to:
• Reflect on practice.
• Share learning from SARs.
• Promote system-wide improvements in safeguarding adults.

Learning Events can take place at various stages:

1. **During a SAR** – to inform the review process and gather practitioner perspectives.
2. **Post-SAR** – to disseminate findings, support shared understanding, and plan implementation.
3. **Follow-up (e.g., one year later)** – to evaluate progress and the impact of SAR recommendations.

Increasingly, SABs are recognising the value of involving adults and family members directly—where appropriate and in line with their wishes—in Learning Events. **Family members are often those who knew the adult best**, offering rich insight into the person's life, strengths, history, relationships, and lived experience of care and support.

When sensitively facilitated, their presence can:

- Strengthen the authenticity and legacy of the adult's voice.
- Deepen practitioner understanding of the adult as a person, not just a review.
- Highlight what mattered most to the adult and family, helping shape more meaningful learning.
- Promote transparency, compassion, and trust in the SAR process.

Boards should consider extending invitations to the adult (where alive) or their family at appropriate stages, ensuring they are fully briefed, supported, and offered choice about how they wish to participate. This could include attending part of the session, sharing reflections via a written statement, contributing through an advocate, or shaping the agenda.

"We wrote a statement for the SAB. The reviewer passed on our contact details to the SAB so that we could be involved in conferences and talk about the process. We have met with SAB members twice for an update on the report's recommendations. We have become involved in informing how future SARs engage with people with lived experience and how services support young carers"
(Family Member)

Research in Practice has produced a practice tool, 'Developing Effective Safeguarding Adult Review Learning Events', to support local SABs, lead reviewers, business managers, and others involved in SARs. It provides practical guidance on planning, facilitating, and evaluating Learning Events as an integral component of the SAR process. It recommends the use of **appreciative inquiry**, enabling practitioners to explore both best practice and areas for development, and ensuring that reviews remain proportionate, strengths-based, and informed by cumulative local and national learning.

This approach not only enhances the quality and relevance of SARs but also respects the experiences of adults and families by avoiding repetition, ensuring their perspectives shape the learning, and reinforcing the principle that safeguarding is most effective when the voice of the person is central.

26.1 Key Components of Effective Learning Events

Creating a Positive Learning Environment	• Foster a blame-free culture. • Promote collaboration, openness, and reflection. • Encourage a 'just culture': focus on systemic issues, not individual blame.

Planning and Preparation	• Clarify the purpose and outcomes of the event. • Involve the right participants (practitioners, managers, strategic leads). • Provide pre-event information and support (e.g., case summaries, expectations). • Address logistics and accessibility to ensure inclusive participation. • Consider how the voice of the adult can be incorporated into the event ie, adult contributing to the content, written statement, short video etc.
Effective Facilitation	• Skilled, independent facilitators are essential. • Use respectful inquiry: open questions, active listening, and non-judgmental language. • Facilitate equal participation, especially from those with less power or visibility.
Supportive Processes	• Establish ground rules and a safe space for honest dialogue. • Use Appreciative Inquiry and professional curiosity to explore practice. • Include interactive activities: small group discussions, case studies, reflective exercises. • Ensure follow-up: summaries, action points, and ongoing engagement.
Virtual Learning Events	• Require careful planning to maintain engagement and psychological safety. • Use platforms with breakout rooms, chat functions, and visual tools. • Keep sessions short and focused (max 3 hours). • Provide clear pre-event communication and post-event feedback opportunities.
Reflection Questions for SABs and Facilitators	• How is a positive learning culture promoted and measured? • Are events structured to empower all voices, especially practitioners? • How are organisations and individuals prepared and supported? • What has changed as a result of SAR learning? What more needs to be done?

27. Impact and Outcome of SARs – Achieving and Evidencing Systemic Change

[SCIE, Quality Marker 15: Action and Impact]

SARs exist not simply to identify what happened in one individual case, but to act as **catalysts for meaningful, measurable, and sustainable system change**. A SAR process may be thorough, compassionate, and professionally executed—from referral through to publication—but its true value is only realised when the learning leads to **demonstrable improvements** in safeguarding practice, culture, and outcomes for adults with care and support needs.

As one adult with lived experience expressed:

> *"Lucky I can vocalise. I hope this report (the SAR) can support people who can't vocalise. I am here to be used as a resource; this is the main goal."*
>
> *(Adult with Lived Experience)*

This perspective reinforces that SARs have a purpose beyond documentation: **they must lead to action, and that action must lead to better safeguarding experiences for adults.**

Similarly, feedback from Family Member illustrates what happens when systems fall short:

> "The process was exceptionally prolonged for a grieving family. We had no sense of movement or where the process was up to. There was no sense of being held by the process. It was too elongated. It felt theoretical, an obligation for the State to fulfil"
> (Family Member)

This underscores the importance not only of a robust SAR process, but of ensuring that **its outcomes translate into real-world improvements**.

The Purpose: Moving Beyond Lessons to Demonstrable Change
While SARs identify learning and generate recommendations, the essential question remains:

"So what has changed because of this SAR?"
A high-quality SAR report and action plan are necessary, but insufficient, without a clear, evidenced line of sight to improvements in safeguarding practice—locally, regionally, and where appropriate, nationally. Too often, agencies complete actions without evaluating whether these actions have led to *actual, observable impact*.

This section recognises that system change is challenging. It often requires culture shift, multi-agency alignment, investment, and leadership. However, without pursuing and evidencing that change, the learning risks becoming static, rather than transformative.

Why Evidencing Impact Matters

Accountability and Assurance

- Demonstrates that partners have acted meaningfully on SAR recommendations.
- Provides assurance to SABs, stakeholders, and the public that change is occurring—not just being discussed.

Learning and Continuous Improvement

- Shows whether changes in policy, practice, or culture have taken effect.
- Identifies where learning has embedded well and where further development is needed.

Sustainable System Change

- Ensures improvements endure beyond the immediate response to the SAR.
- Reduces the likelihood of repeat patterns or recurring safeguarding concerns.

Strategic Influence

- Contributes to local, regional (e.g., GM), and national learning.
- Informs policy development, commissioning, workforce planning, and resource allocation.

Transparency and Trust

- Demonstrates to adults, families, and practitioners that learning translates into safer, more responsive systems.
- Reinforces the credibility and purpose of the SAR process.

How Evidence of Impact Should Be Demonstrated

To ensure SARs lead to transparent, sustainable change, the following principles should underpin impact monitoring and evaluation:

- **Clear, SMART recommendations and action plans** that identify both the intended change and how it will be measured.
- **Outcome-focused performance indicators**, not just task completion.
- **Multi-method evaluation**, including audit, case sampling, data analysis, and qualitative feedback.
- **Follow-up reviews at 6, 12, and 18 months** to determine whether learning has been embedded.
- **Evidence from practitioners, adults with lived experience, and families** to understand the real-world effect of changes.
- **Governance structures that prioritise impact over activity**, including Workstream 3 (from February 2026) which will focus explicitly on evaluating and reporting safeguarding improvements linked to SAR outcomes.

- **Sharing learning openly**—locally, regionally, and via national libraries—to support wider system development.

SARs are not retrospective exercises; they are instruments of **future-focused improvement**. Their success cannot be measured by the quality of the report alone, but by the **real-world safeguarding improvements** that follow. Meaningful systemic change requires commitment, clarity of purpose, and robust evidencing. When this is achieved, SARs contribute to safer practice, more confident professionals, and better outcomes for the adults they exist to protect.

28. Legal Support and Advice

SARs can involve complex legal considerations, particularly where issues of confidentiality, data protection, and potential liability arise. Access to timely and appropriate legal advice ensures that the review process is compliant with statutory duties under the Care Act 2014, respects the rights of individuals, and mitigates risks for partner agencies. Legal input may be required at various stages—from drafting Terms of Reference to managing sensitive information or responding to media interest.

This section sets out when and how legal support should be sought, the role of legal advisors in multi-agency reviews, and practical steps for integrating legal guidance into SAR governance.

Legal Support to the Local SAB

The SAB's legal advisor (often from the local authority but this may vary in local areas) provides:

- **Interpretation of the Care Act 2014**, especially Section 44 regarding SARs.
- Advice on **whether a circumstance of the adult meets the criteria** for a SAR.
- Guidance on **data protection**, **confidentiality**, and **information sharing** under the UK GDPR and Data Protection Act 2018.
- Support in **drafting terms of reference**, ensuring they are legally sound and proportionate.
- Oversight of **contractual arrangements** with independent reviewers.
- Attendance at the SAR Review Group to have oversight when requested
- Attendance at the panel for acceptance of the final report.

Legal Input from Partner Agencies

Each statutory partner (e.g., NHS, Police, Probation) may involve their own legal teams to:

- Review and approve the **release of records** or sensitive information.
- Ensure **compliance with parallel investigations** (for example, criminal, coroner's inquests, regulatory inquiries).
- Advise on **duty of candour** and **corporate responsibilities**.

- Support internal staff involved in the SAR process, especially where there may be **employment or disciplinary implications**.

Risk Management and Liability

Legal advisors help to:

- Identify and mitigate **legal risks** (defamation, breach of confidentiality).
- Ensure that **publications** (SAR reports) are legally defensible and appropriately redacted.
- Advise on **media responses**, especially for adults who are deemed to be high-profile

Supporting Publication and Learning

- Legal teams can review **final SAR reports** to ensure they are:
    - Accurate and fair.
    - Free from defamatory or prejudicial content.
    - Compliant with the **Human Rights Act 1998** and **Equality Act 2010**.
    - They might also advise on **dissemination strategies** to ensure learning is shared safely and effectively.

29. Media and Comms (including social media)

Managing media and communications during a SAR is a critical aspect of maintaining public confidence, protecting the dignity of those involved, and ensuring transparency without compromising confidentiality. SARs often attract media attention, particularly where circumstances involve serious harm or death, and can raise sensitive issues for families, professionals, and partner agencies.

When an adult is known to multiple agencies or where there are parallel processes—such as a Domestic Abuse Related Deaths Reviews (DARDR) or Child Safeguarding Practice Review (CSPR)—a **coordinated communications approach** is essential. This ensures consistent messaging, prevents conflicting statements, and supports collaborative engagement with the media. This section outlines principles for proactive media engagement, guidance on responding to press enquiries, and practical steps for aligning communications across all involved partners.

Managing public and media interest is crucial, especially regarding those adults who are seen as high-profile. Best practices include:

Proactive Communication

- Develop a **media strategy** early in the SAR process.
- Designate a **communications lead** to liaise with press and stakeholders.
- Prepare **holding statements** and **FAQs** for anticipated queries.

Confidentiality and Sensitivity

- Avoid sharing identifiable information unless legally cleared.
- Respect the wishes of families regarding publicity.

Social Media Management

- Monitor platforms for misinformation or speculation.
- Respond with **factual, non-inflammatory** updates if necessary.
- Use social media to **share learning** from SARs in a constructive way.

Engaging Families and the Public

- Offer families the opportunity to contribute to the review.
- Provide clear, compassionate updates on the process and outcomes.

Role of the Independent Chair

- May act as the **public spokesperson** for the SAB, or delegate this to a communications lead.
- Approves or contributes to **press releases**, **public statements**, and **responses to media inquiries**.
- Ensures that any public messaging:
  - Protects the dignity and privacy of the adult and their family.
  - Clearly communicates the purpose of the SAR (learning, not blame).
  - Avoids speculation or premature conclusions.

30. Complaints and Compliments from Members of the public

Complaint

It is essential that adults, their families, and their representatives feel comfortable and supported in raising concerns or making complaints about the SAR process. This commitment reflects the principles of transparency, accountability, and Making Safeguarding Personal. A trusted and fair process encourages openness and maintains confidence in the review.

Complaints may relate not only to the SAR process itself, but also to the conduct or approach of the Independent Reviewer, or to the actions of any agency contributing to the review. Likewise, the right to raise a concern is not limited to the adult or their family.

The Independent Reviewer, or any participating agency, may also need to raise a concern or complaint if they identify issues that could compromise the integrity, fairness, or effectiveness of the SAR.

To ensure clarity and consistency, all these potential routes for raising concerns must be addressed within local processes, including how complaints are received, how they will be considered, and how the outcomes will be communicated.

Robust local guidance ensures accountability for all parties and supports a transparent, well-governed SAR process.

> **"Coordination and communication could be improved, between the SAB chair and the reviewer, and with us. It was a struggle for and we have professional careers, so what would it have been like for others? Advocacy was not available for us"**
> (Family Member)

What is a Complaint?

A complaint is an expression of dissatisfaction about a service, action, or decision made by an organisation or professional—whether justified or not. Complaints can be made by the adult themselves, their family, or third parties, and may relate to issues such as poor service, misconduct, delays, or failure to follow proper procedures.

Clear information should be provided to the adult or their family at the outset about **how to raise a concern**, what the complaints process involves, and the assurance that doing so will not negatively impact their involvement. Complaints should be handled promptly, respectfully, and in a way that promotes learning and improvement. By embedding this approach, SABs demonstrate their commitment to safeguarding values and to creating a process that is inclusive, responsive, and focused on continuous improvement.

Purpose of a Complaint Process

The complaint process aims to:

- Resolve issues raised by adults using services or the public.
- Improve service quality by identifying areas of weakness or failure.
- Promote accountability and transparency in public and private organisations.
- Protect rights and ensure fair treatment.
- Encourage learning and prevent recurrence of similar issues.

Effective complaint handling also helps build trust and confidence in services and institutions.

Legal and Regulatory Framework

The legal framework for complaints varies depending on the sector, but generally includes:

Public Sector Complaints:

- Governed by UK Central Government Complaint Standards and sector-specific regulations.

- Oversight by bodies such as the Parliamentary and Health Service Ombudsman, Local Government and Social Care Ombudsman, and Public Services Ombudsman for Wales.

Health and Social Care:

- The Local Authority Social Services and NHS Complaints (England) Regulations 2009.
- Complaints can escalate to the Health Service Ombudsman and/or the Local Government and Social Care Ombudsman.

Legal Services:

- Regulated by the Legal Ombudsman, which enforces standards and handles unresolved complaints.
- The Model Complaints Resolution Procedure aims to standardise and improve complaint handling in legal services

Where a complaint is received about a Board's process, for example a SAR, this will initially be responded to by the Board Manager in consultation with the SAB Independent Chair, with a written response within 28 days of receipt.

Local SABs are encouraged to ensure they have information available to the public about their local complaints process to ensure transparency.

Top tips to support a robust approach;

Promote a Culture of Constructive Challenge	• Encourage **open dialogue** among SAR participants, including practitioners, families, and reviewers. • Set expectations early that **challenge is welcomed** as part of learning—not blame. • Use **facilitated reflective sessions** to surface differing views safely.
Establish Clear Escalation Routes	• Define a **clear escalation process** in SAR protocols for: – Disagreements over findings or recommendations – Concerns about process fairness or delays • Escalations should be reviewed by a **SAR oversight or QA subgroup**.
Manage Disagreements with Reviewers	• Include a clause in the commissioning letter about how to handle disputes. • Use **mediation or peer review** if consensus cannot be reached on key findings.

Handle Complaints Transparently	• Develop a **SAR-specific complaints procedure** aligned with the SAB's wider complaints policy. • Ensure complaints can be made by: – Family members or advocates – Professionals or agencies involved • Respond within clear timeframes and document all outcomes.
Maintain an Audit Trail	• Record all challenges, escalations, and complaints, including: – Who raised the issue – How it was addressed – Any changes made to the SAR process or report • Use this data to inform **future SAR improvements**.
Supportive Communication	• Keep all parties informed of how their concerns are being handled. • Offer **debriefs or follow-up meetings** to explain decisions and outcomes.

Compliment

When a compliment is received about good practice or the way a SAR was conducted, it is considered best practice for the SAB to:

1. **Acknowledge and record the compliment** formally within the SAR documentation or meeting minutes. This helps reinforce a culture of learning and appreciation within safeguarding work.
2. **Share the positive feedback** with the individuals or agencies involved. Recognising good practice boosts morale and encourages continued high standards in safeguarding responses.
3. **Incorporate the compliment into learning dissemination**. Highlighting what went well in SARs is just as important as identifying areas for improvement. It supports a balanced approach to learning and promotes reflective practice across the partnership.
4. **Use the feedback to inform future SARs**. Compliments can help shape methodologies, reinforce effective approaches, and guide the development of SAR protocols and reviewer training.
5. **Include in annual reports or learning summaries**. This ensures that good practice is visible at a strategic level and contributes to sector-wide improvement.

31. Other Statutory and Non Statutory Reviews

[SCIE, Quality Marker 8: Parallel Processes]

While SARs are a statutory duty in their own right, they do not exist in isolation. In many situations, other statutory or formal review processes may run in parallel — such as Domestic Abuse Related Death Reviews (DARDRs), Child Safeguarding Practice Reviews (CSPRs), or Serious Incident Investigations. The next part of this guidance provides a high-level overview of these other statutory review processes to support clarity, coordination, and effective interface management across all review pathways.

31.1 Domestic Abuse Related Deaths Reviews (DARDR)

A **DARDR,** previously called a **Domestic Homicide Review (DHR)**, is a statutory review carried out when a person aged 16 or over dies as a result of violence, abuse, or neglect by a relative, intimate partner, or household member.

The term **DARDR** reflects a broader scope than DHRs, covering not only homicides but also suicides and other deaths linked to domestic abuse, including coercive control, emotional, and economic abuse.

Purpose of a DARDR

The review aims to:

- **Identify lessons** about how agencies worked together to safeguard victims.
- **Improve multi-agency responses** by applying those lessons to policies and practice.
- **Prevent future deaths** through better services for victims and families.
- **Centre the victim's voice** using a trauma-informed, victim-focused approach.

Legal Framework

- **Statutory Basis:**
  - Domestic Homicide Reviews (DHRs) were established under **Section 9 of the Domestic Violence, Crime and Victims Act 2004**.
  - The UK Government announced its intention to replace Domestic Homicide Reviews (DHRs) with Domestic Abuse Related Death Reviews (DARDRs) on 5 February 2024. The change was subsequently enacted through Part 1, Section 19 of the Victims and Prisoners Act 2024. The relevant provisions came into force on 15 September 2026, when DARDRs formally replaced DHRs in England and Wales.
  - This change reflects the full scope of deaths resulting from domestic abuse, not just physical violence.

- **Statutory Guidance:**
  - Revised statutory guidance for the conduct of DARDRs was published on 15 September 2026. Domestic abuse related death reviews: statutory guidance - GOV.UK

- **Governance:**
  - Reviews are commissioned by **Community Safety Partnerships (CSPs)** and must follow Home Office Guidance.
  - Reports require submission to the **Home Office Quality Assurance Panel** for sign-off before publication.
  - Unlike SARs, DARDRs carry a **statutory duty to publish**, ensuring transparency and accountability.
  - Learning should be shared locally without delay, even while awaiting national sign-off.

31.2 Child Safeguarding Practice Review (CSPR)

A **CSPR** is a statutory review conducted when a child dies or suffers serious harm and abuse or neglect is known or suspected. These reviews aim to understand what happened, why it happened, and how services can improve to better protect children in the future.

Purpose of a CSPR

The review seeks to:

- **Identify learning** from serious child safeguarding cases.
- **Improve multi-agency working** to safeguard and promote children's welfare.
- **Understand systemic issues** that contributed to harm.
- **Promote transparency and accountability** in safeguarding practice.
- **Share findings nationally** to inform policy and practice across England.

Legal Framework

Primary Legislation:

- Children and Social Work Act 2017 – established the legal basis for CSPRs and the national Child Safeguarding Practice Review Panel.

Regulations:

- **The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018** – set out responsibilities of safeguarding partners and criteria for reviews.

Statutory Guidance:

- **Working Together to Safeguard Children 2026** – outlines the process for identifying, notifying, and conducting reviews.
- **Child Safeguarding Practice Review Panel Guidance (updated 2025)** – provides detailed operational guidance for safeguarding partners.

Local Governance (England)

Responsibility for **Local Child Safeguarding Practice Reviews (LCSPRs)** rests with the three statutory safeguarding partners:

- **Local Authority**
- **Chief Officer of Police**
- **Integrated Care Board**

These partners must:

- Decide whether a local review is required when a child dies or suffers serious harm due to abuse or neglect.
- Notify the national Panel of serious incidents.
- Commission and oversee the review process locally.

31.3 Learning from Lives and Deaths (LeDeR)

The LeDeR programme is a national service improvement initiative in England that reviews the deaths of people with a learning disability or autism, aged 4 years and over. It aims to understand the circumstances leading to their deaths and identify ways to improve health and social care services.

Originally launched in 2015, LeDeR was developed in response to the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD), which highlighted significant health inequalities and preventable deaths.

LeDeR (Learning from lives and deaths) reviews are generally **not a statutory process** in the legal framework in the UK. They are a national service improvement programme, commissioned by NHS England, aimed at identifying lessons to improve the health and social care for people with learning disabilities and autistic people.

Purpose of LeDeR

The core aims of the LeDeR programme are to:

- Improve care quality for people with learning disabilities and autism.
- Reduce health inequalities and prevent premature deaths.
- Identify learning from individual cases to inform local and national service improvements.

- Promote accountability and transparency in health and social care systems.
- Ensure family involvement in the review process, valuing their insights and experiences

Legal and Policy Framework

- **Policy Basis:** The LeDeR programme is not a statutory review like a SAR or Child Safeguarding Practice Review (CSPR), but it is mandated by NHS England and embedded in national policy.
- **Guidance:** The current policy framework (2021, updated 2023) outlines the responsibilities of local systems, the review process, and expectations for quality and timeliness

Governance: Delivered through Integrated Care Boards (ICBs), with oversight from NHS England's national LeDeR team.

It is considered best practice for local SABs to receive regular assurance reports on the outcomes and impact of LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People) reviews. These reports provide assurance that learning from deaths is being translated into tangible improvements in care and safeguarding practice.

SABs should also establish a clear protocol for the interface between LeDeR reviews and Safeguarding Adults Reviews (SARs), recognising that in some cases both processes may be relevant.

A coordinated approach:

- Supports effective decision-making.
- Avoids duplication of effort.
- Ensures learning is shared across systems.

This protocol should set out:

- Referral pathways.
- Decision-making responsibilities.
- How findings from each review type will be aligned and disseminated.

By embedding these arrangements, SABs can strengthen transparency, reduce unnecessary burden on families, and promote systemic improvements across health and social care.

31.4 Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) is the NHS's national approach to responding to patient safety incidents. It replaces the previous Serious Incident Framework (2015) and represents a significant shift toward a more learning-

focused, systems-based response to incidents in healthcare settings. The Patient Safety Incident Framework isn't a statute itself, buts its contractually mandatory for most NHS Providers in England.

Purpose of PSIRF

PSIRF aims to:

- Promote learning and improvement rather than blame.
- Support compassionate engagement with patients, families, and staff affected by incidents.
- Encourage system-based investigations to understand how and why incidents happen.
- Enable proportionate responses to incidents based on risk and impact.
- Strengthen organisational safety systems and foster a culture of continuous improvement.

Legal and Policy Framework

- **Mandated by:** NHS England as part of the NHS Patient Safety Strategy.
- **Contractual Requirement**: PSIRF is a requirement under the NHS Standard Contract, making it mandatory for NHS-funded services including acute, mental health, ambulance, and community providers.
- **Oversight**: NHS England provides national guidance, tools, and oversight to support local implementation.

31.5 Drug-Related Death (DRD) Reviews and Panels

Drug-Related Death (DRD) Reviews are multi-agency processes that seek to understand the circumstances leading up to a person's death where drug use—whether illicit, prescribed, or diverted medication—was a contributing factor. Their purpose is not to apportion blame, but to promote learning, strengthen partnership working, and identify opportunities for earlier intervention and harm reduction.

DRD Reviews are usually convened when a death involves overdose, toxicity, or complications linked to substance use, including deaths that occur in the context of dual diagnosis, homelessness, criminal justice involvement, or safeguarding concerns. These reviews bring together representatives from health, social care, substance misuse services, primary care, mental health, criminal justice agencies, and emergency services to form a shared picture of the individual's journey. Where relevant, voluntary and community sector partners—including outreach teams, housing providers, and peer support services—are also involved to ensure that learning reflects the full breadth of the person's contact with services.

A Drug-Related Death Panel typically oversees this process. The Panel provides strategic coordination, ensures consistent standards of review, and monitors emerging

themes or trends across multiple cases. It also holds responsibility for identifying system-level learning and escalating issues that require wider policy, commissioning, or operational change. Many panels operate across local authority or sub-regional footprints, ensuring alignment between community safety, public health, safeguarding adults, and drug and alcohol partnership arrangements.

Learning from DRD Reviews often centres on:

- opportunities for earlier identification of risk,
- communication and information-sharing between services,
- access to evidence-based treatment and harm reduction,
- transitions between services (e.g., prison release, hospital discharge),
- engagement approaches for individuals who may be reluctant or unable to access traditional services, and
- the role of trauma-informed, person-centred practice.

For local SABs, Drug-Related Death Reviews provide vital insights into the complex interplay of substance use, exploitation, self-neglect, homelessness, and mental health. They complement, rather than duplicate, statutory SARs by focusing on preventable harm and system learning in cases that may not meet the SAR threshold but nonetheless present significant opportunities for improvement. Effective alignment between Drug Related Death Panels and SAB learning mechanisms ensures that themes are captured, disseminated, and embedded across local systems.

32. Joint Statutory Reviews Across Adults, Children and Domestic Abuse

Safeguarding situations can sometimes cut across the boundaries of adult services, children's services, and domestic abuse. In these circumstances, the *Care and Support Statutory Guidance* (paragraphs 14.174–14.175) advises that joint reviews should be considered to reduce duplication, minimise distress for families, and maximise opportunities for shared learning across systems. Joint consideration may include a SAR, CSPR, and DARDR – or all three.

Each SAB should engage with other Boards/Partnerships, and with bodies such as ICBs and NHS England, to develop and/or review a protocol for decision-making when the criteria for more than one type of review appear to be met.

In line with the national improvement priority identified in the Second SAR Analysis, SABs should also ensure that their local protocols actively promote

consistent cross-boundary working and contribute to the wider national aim of strengthening coherence, transparency, and shared learning across all types of statutory and non-statutory reviews. This guidance supports local SABs to develop internal protocols that set out a consistent, collaborative, and trauma-informed approach for determining when and how joint reviews should take place.

Please Note: Some content in this section intentionally repeats earlier material in the guide. As this is an interactive document and SARs often interface with joint reviews, key points are included here to ensure clarity, reduce the need to cross-navigate, and keep all relevant information at the reader's fingertips.

Aims of a Joint Review

A joint approach seeks to:

- **Reduce duplication** across agencies and prevent parallel processes examining the same events.
- **Minimise distress** for families by reducing repeated requests for information.
- **Maximise learning** through an integrated understanding of the adult, child, and domestic abuse dimensions.
- **Drive coordinated change** by aligning recommendations and promoting system-wide improvement.
- **Ensure statutory duties** for each review type are upheld.

When to Consider a Joint Review

A joint review (SAR–CSPR–DARDR) should be considered where one or more of the following apply:

- **Overlapping Harm or Risk**
  - The adult at risk is connected to a child who has been harmed or is at risk.
  - Domestic abuse is a significant factor in the circumstances.
  - There is a shared perpetrator, relationship, or household environment.

- **Intersecting Chronologies**
  - Key events involve both adult and children's services.
  - Emerging issues suggest systemic concerns that cut across organisational or age-based boundaries.

- **Multiple Statutory Review Criteria Are Met**
  Examples:
  - SAR criteria **and** CSPR thresholds are triggered.

- SAR criteria **and** the statutory threshold for a DARDR are met.
- Or all three – SAR, DARDR and CSPR

Early Decision-Making Process

Connectivity between individual Business Units

Once a referral is received, and there are indications that the concerns also involve children and/or domestic abuse, you should contact your counterpart in the relevant business unit(s) to discuss and co-ordinate how the referral will be screened. There should be a locally agreed arrangement between the business units to ensure that communication on receipt of such referrals is two-way.

This discussion should include agreeing who will take the lead in managing the referral and ensuring it progresses through the appropriate internal processes. Decision-making should be undertaken jointly, with all relevant partners and decision-makers involved.

Senior Leadership Notification

Senior Leaders should be advised at the earliest opportunity, if possible within **5 working days** of identifying a potential joint review, the following partnerships should notify one another:

- Safeguarding Adults Board (SAB)
- Safeguarding Children Partnership (SCP)
- Community Safety Partnership (CSP)

Joint Scoping Meeting – for decision making whether criteria have been met

This should take place at the earliest opportunity, with the following minimum representation:

- SAB Business Manager.
- SCP Manager.
- Community Safety / Domestic Abuse Review Coordinator.
- Police.
- Health (adult and children).
- Local Authority (adult and children's social care).
- Legal services.

Purpose:

- Share initial information.
- Confirm which review criteria are met.
- Decide on which Business Unit should lead on the review.

Possible Decision Outcomes

1. Fully Integrated Joint Review - One reviewer, one methodology, one report.

Best when:

- Issues are relational, family-based, or system-wide.
- Agencies involved are similar across adult/child spheres.
- Minimising duplication is a priority.

2. Parallel Reviews with Shared Governance - Separate reports but shared:

- Terms of Reference.
- Chronology.
- Methodology meetings.
- Practitioner learning events.

Best when:

- Statutory frameworks differ significantly.
- Timescales or legal thresholds are misaligned.
- Sensitive child-specific content cannot be integrated.

3. Separate Reviews with Light Collaboration

Independent reviews that still share emerging learning or key lines of enquiry.

Best when:

- Only limited areas overlap.
- Information-sharing constraints prevent fuller integration.

32.1 Governance and Oversight

Effective governance is crucial when coordinating a joint review that spans adult safeguarding, children's safeguarding, and domestic abuse. Clear structures, shared leadership, and coordinated methodologies help ensure that learning is coherent, the family experience is not duplicated, and each statutory framework is respected.

Where a joint review is commissioned, funding arrangements between the respective Boards should be agreed at the outset; however, these discussions must not delay the initiation or progress of the review (see section 'Shared Funding of Statutory Reviews (Cross Boarder or Joint Reviews)

Joint Review Panel

A Joint Review Panel should be established at the outset to oversee the process, provide strategic direction, and ensure that the different safeguarding domains are aligned.

Panel representation should include:

- Adult services.
- Children's services.
- Domestic abuse specialists.
- Police.
- Health.
- Legal advisors.

Members must have sufficient seniority to support decision-making, resolve interface issues, and endorse joint learning and recommendations.

Chairing Options

- The chairing model should reflect the complexity of the case, the level of cross-system involvement, and the need for balanced oversight. Options include:
- Single independent chair – provides clear leadership and a unified oversight structure.
- Co-chair model (adult, community safety and/or children's leads) – ensures equal weight across all safeguarding domains.
- Rotating chair based on emerging themes – useful where different specialisms are needed at different stages.
- Whichever option is chosen, chairing arrangements must support objectivity, transparency, and coordinated decision-making**.**

Reviewer Appointment

- Early decisions should be made about the review team. Options include:
- A single reviewer, where one person has the expertise to cover all domains proportionately; or
- A co-reviewer arrangement, pairing adult, community safety and/or children's specialists to ensure depth and accuracy across both areas.
- Reviewers must work collaboratively to produce a single, coherent analysis rather than parallel or fragmented reports.

Developing Joint Terms of Reference (ToR)

A joint ToR is essential for ensuring clarity, alignment, and proportionality. It should clearly define:

- The purpose and scope of the review.
- Key lines of enquiry across adult, child, and domestic abuse contexts.
- Relevant legal frameworks (Care Act 2014, Working Together to Safeguard Children 2026, Domestic Abuse Act 2021).

- Timeframe for the review.
- Methodology, including any joint or parallel approaches.
- Family involvement and engagement.
- Information governance and data-sharing requirements.
- Publication and media strategy.

For more detail, see the section titled Section Terms of Reference for a SAR

Please note – DARDRs must comply with the Home Office statutory guidance, including the required layout, structure and formatting of the Overview Report. Failure to meet these prescribed standards might result in the report being rejected by the Home Office Quality Assurance Panel. These requirements arise from the statutory basis for DARDRs under **Section 9 of the Domestic Violence, Crime and Victims Act 2004**, and the expectations set out in the statutory guidance, including the standards for the structure and publication of the Overview Report (see **Section 30.1**)."

Where a joint SAR and DARDR is undertaken, these statutory requirements must be fully taken into account from the outset. The DARDR elements of the review must be presented in a format that aligns with the Home Office DARDR template and quality assurance expectations, to avoid non-compliance or rejection. This may require adapting the joint report's structure so that it meets DARDR standards while still fulfilling SAR requirements."

In addition, to offer family involvement is a mandatory component of DARDRs. The statutory guidance and associated protocols outline the expectation that family, friends, and other informal networks are offered meaningful opportunities to contribute to the review and are supported to do so (see DARDR protocol sections on family involvement). This requirement remains mandatory within any joint SAR/DARDR process and must be planned for accordingly to ensure statutory compliance.

Methodology

Integrated Chronology

- Where legally permissible, a single integrated chronology should be developed to reduce duplication and support a unified understanding of cross-system interactions**.**

Practitioner Learning Events

Hold joint reflective sessions to:

- Map interactions across adult, child, and domestic abuse systems.
- Explore assumptions, interface issues, and thresholds.

- Strengthen multi-agency understanding and shared learning.

Parallel Specialist Sessions

These may be required where:

- Sensitive child safeguarding information cannot be shared beyond statutory partners.
- Domestic homicide content is confidential.
- Court processes (Family Court, criminal proceedings) restrict disclosure.

Voice of the Adult, Child, and Family

A trauma-informed, coordinated approach is essential. Best practice includes:

- A single family liaison lead to reduce duplication.
- A joint introductory letter outlining the process.
- Access to advocacy and emotional support.
- Flexible options for contributing to the review.
- Clear, compassionate communication about publication decisions.

Legal, Information Governance, and Data Sharing

A single multi-agency information-sharing agreement should be established at the outset to ensure lawful, proportionate, and transparent data sharing.

Considerations should include:

- Ongoing criminal investigations.
- Family Court restrictions.
- Inquest requirements.
- Duties linked to Domestic Abuse Related Deaths Reviews.
- Data minimisation obligations and early legal oversight to prevent breaches or delays.

Timescales

Joint reviews must respect statutory timescales across different frameworks:

- SAR: usually 6 months.
- CSPR: rapid review within 15 working days; full review varies.
- DARDR: aligned with Home Office timescales unless local arrangements differ.

A realistic joint timeline should be agreed early, monitored closely, and revised only when justified.

Report Writing and Publication

A joint report must integrate findings from all involved safeguarding domains. Components typically include:

- Executive summary.
- Methodology.
- Family perspective.
- Integrated analysis.
- Systemic findings.
- Joint and single-agency recommendations.
- Joint action plan.

Publication decisions may involve:

- A single joint report.
- Separate summaries for each Board or Partnership.
- Redactions where required.
- A coordinated communications and media strategy.

Please note - publication of a SAR and CSPRs should be encouraged wherever possible, recognising the importance of transparency and ensuring that learning is shared widely. However, there may be circumstances where it is not appropriate to publish the full report (see section **Why SARs Are Expected to Be Published and Why It Matters**; in such cases, a learning summary or learning document should be published instead to ensure that key learning is still disseminated.

This differs from Domestic Abuse Related Death Reviews (DARDRs), which are established under **Section 9 of the Domestic Violence, Crime and Victims Act 2004** and must adhere to statutory publication requirements. The statutory guidance specifies that the **Overview Report must be published** (see Section 24: Publication of the Overview Report).

Action Planning and Embedding Learning

To ensure learning leads to real-world improvement:

- Develop a joint multi-agency action plan with clear ownership.
- Deliver shared learning events to embed new practice.
- Review implementation and impact 6–12 months post-publication.
- This ensures that lessons from the review translate into sustainable and measurable improvement across all safeguarding systems.



Core Principles

- **Early identification** of potential joint reviews.
- **Respect for distinct statutory frameworks.**
- **Coordinated governance** and clear roles.
- **Shared methodologies** where possible.
- **Unified learning outputs** to strengthen system improvement.
- **Timeliness and efficiency**, reducing duplication and cost.

Additional Best Practice

- Strengthen information-sharing with GDPR-compliant agreements.
- Promote cultural competency and trauma-informed practice.
- Create a regional pool of qualified reviewers.
- Use SMART joint learning plans with robust accountability.

32.2 Examples of Joint SAR/DARDR

- Bristol SAR/DHR for "Caroline" used a combined approach to explore self-neglect, domestic abuse, and agency responses.
- The joint SAR/DHR for "Anna" in Luton highlighted barriers to accessing support and the need for trauma-informed practice.
- Essex SAB published a joint SAR/DHR for "Valerie," highlighting themes like carer assessments, coercive control, and mental health service coordination.

32.3 Examples of Joint SAR/CSPR

- Joint Adults' and Children's Review | Salford Safeguarding Adults Board highlights themes including Cultural Awareness, Impact of Covid-19 pandemic, Professional response to neglect, Think Family - multi agency working, Equality Act (2010) and Voice of the family and their lived experience

33. Other Parallel Processes

Where multiple parallel processes are underway, the SAR must consider that the relationships *between* those processes may be as significant to the learning as their individual interfaces with the SAR itself.

33.1 Coronial Inquest

National SAB Guidance on the Interface between SARs and Coronial Processes

A Coroner's Inquest is a judicial inquiry held to determine the facts surrounding a person's death. It is not a trial and does not assign blame or liability. Instead, it seeks to answer four key statutory questions:

1. **Who** the deceased was
2. **When** they died
3. **Where** they died
4. **How** they came by their death

Inquests are held in cases of sudden, unexplained, violent, or unnatural deaths, or deaths in custody or state detention

Purpose of a Coroner's Inquest

The inquest aims to:

- Establish the facts surrounding a death.
- Provide transparency and public accountability, especially where public bodies may be involved.
- Identify any lessons or systemic issues that could prevent future deaths.
- Offer closure to families by clarifying the circumstances of the death.

Legal Framework

- **Coroners and Justice Act 2009** – the primary legislation governing coroners' duties and powers.
- **The Coroners (Inquests) Rules 2013** – sets out the procedures for conducting inquests
- **Human Rights Act 1998** – particularly Article 2 (Right to Life), which underpins the requirement for certain inquests to meet enhanced standards.

What is an Article 2 or Article 5 Inquest?

An Article 5 Inquest refers to an inquest that engages Article 5 of the European Convention on Human Rights, which protects the right to liberty and security. This typically applies when a person dies while in state detention, such as:

- Police custody
- Prison
- Mental health detention under the Mental Health Act

These inquests are often also Article 2 inquests, which require a more thorough investigation into the circumstances and systemic factors surrounding the death, including potential failures by the state to protect life.

Purpose of Prevention of Future Death Report (Regulation 28) Reports

The main aims are to:

- Highlight risks or systemic failings identified during the inquest.
- Prompt action by relevant individuals, organisations, or public bodies to address those risks.
- Prevent similar deaths from occurring in the future.
- Promote transparency and accountability in public services and systems.

These reports are not about assigning blame but about learning and improvement.

Legal Framework

Primary Legislation:

- Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 – gives coroners the power to make reports to prevent future deaths.

Regulations:

- Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013 – set out the process for issuing and responding to PFD reports.

Response Requirement:

- Recipients of a Regulation 28 report must respond within 56 days, outlining what action they have taken or plan to take—or explaining why no action is proposed.

Oversight and Publication:

- All reports and responses are sent to the Chief Coroner and are usually published on the Courts and Tribunals Judiciary website, ensuring public access and scrutiny.

33.2 Criminal Investigations

A criminal investigation is a process carried out by police or other law enforcement agencies to determine whether a crime has been committed, identify the perpetrator, and gather evidence to support prosecution. It can be reactive (responding to a reported crime) or proactive (preventing or detecting crime before it occurs).

Legal Framework

Criminal Procedure and Investigations Act 1996 (CPIA)

- Defines a criminal investigation as one conducted with a view to determining whether a person should be charged or whether a person charged with an offence is guilty of an offence.
- Sets out duties for investigators, including disclosure of evidence.

Police and Criminal Evidence Act 1984 (PACE)

- Governs police powers such as arrest, search, detention, and interviewing suspects.
- Ensures investigations (covered by College of Policing Approved Practice) are conducted lawfully and with respect for individual rights.

Human Rights Act 1998

- Investigations must comply with rights such as the right to a fair trial (Article 6) and the right to liberty (Article 5).

Code of Practice for Victims of Crime

- Ensures victims are treated with dignity and kept informed throughout the investigation.

College of Policing Authorised Professional Practice (APP)

- Provides national guidance on investigative standards, ethics, and procedures.

34. Managing SARs Across Local Authority Boundaries

SARs sometimes involve individuals whose circumstances span more than one local authority area or region. These situations require careful coordination between local SABs to ensure statutory duties are met, learning is captured effectively, and families experience a consistent and respectful process. A collaborative approach helps avoid

duplication, clarifies accountability, and supports the development of shared recommendations that drive systemic improvement across all involved areas.

Referral and Initial Considerations

- **Initial Referral:** The SAR referral should be made to the SAB in the area where the **adult died or where the serious incident occurred** (*Care Act Statutory Guidance, Chapter 14, paragraphs 14.162*).
- **Cross-Border Complexity:** If the adult lived in one area but the incident occurred in another, or if they were known to services in multiple areas, this creates a need for joint discussion.
- **Early Communication:** As soon as cross-border involvement is identified, notify all relevant SABs to avoid delays and ensure transparency.

Decision-Making on Lead SAB

When determining which SAB should lead:

- **Focus on Learning:** The decision should be based on where the most significant learning lies, not just geography.
- **Factors to Consider:**
    - How well the adult was known to agencies/services in each area.
    - The level of involvement and responsibility of each SAB.
    - Which area's systems and processes are most likely to benefit from learning.
- **Joint Leadership:** If learning spans multiple areas, consider a jointly led review with shared governance and resources.
- **Document the Rationale:** Record the decision-making process, including reasons for lead SAB selection, to ensure defensibility.

Governance and Coordination

- **Joint Protocol:** Develop a Memorandum of Understanding (MoU) between regional SABs outlining roles, responsibilities, and decision-making processes.
- **Lead Reviewer:** Agree on whether to appoint a single independent reviewer or co-reviewers for a joint process.

- **Shared Terms of Reference:** Ensure these meet statutory requirements for all involved SABs.
- **Escalation Routes:** Include clear mechanisms for resolving disagreements between SABs.

Family Engagement

- **Consistency:** Families should receive clear, coordinated communication from a single point of contact, even if multiple SABs are involved.
- **Advocacy:** Offer independent advocacy and trauma-informed support throughout the process.
- **Transparency:** Explain why multiple SABs are involved and how this benefits learning and outcomes.

Information Sharing

- **Legal Compliance:** Develop a joint data-sharing agreement aligned with GDPR and safeguarding legislation.
- **Secure Channels:** Use encrypted systems for sharing sensitive information.
- **Timeliness:** Agree on deadlines for information exchange to avoid delays in the review process.

Additional Good Practice

- **Multi-Agency Connectivity:** If the adult experienced domestic abuse, coercive control, or had children, inform the local **Safeguarding Children Partnership** and **Community Safety Partnership**.
- **Learning Dissemination:** Plan joint learning events and shared publications to ensure findings reach all relevant agencies.
- **Cost-Sharing:** Agree on how costs for independent reviewers and administration will be split between SABs.

Example

SAR YI Cross Borough SAR

This Safeguarding Adults Review was jointly commissioned by the Chairs of the Newham, City and Hackney, and Islington SABs in recognition that Yi's experiences spanned organisational and geographical boundaries. During the period examined by

the review, Yi was supported by several of the agencies, and his circumstances highlighted challenges that no single borough could fully understand in isolation.

By commissioning the review collectively, the Boards sought to ensure an **independent, system-wide view** of the events surrounding Yi's journey, and to examine whether each area had effective arrangements in place for adults who are homeless and have care and support needs.

This joint approach reflects the shared commitment of all three Boards to understand the experiences of adults with complex needs more fully, strengthen multi-agency practice, and ensure that learning from the findings leads to meaningful improvements across local systems.

35. Shared Funding of Statutory Reviews (Cross Border or Joint Reviews)

Cross Boarder Reviews often arise when:

- Multiple SABs are involved because the adult's circumstances span over more than one authority area.
- There is a joint process with other statutory reviews, such as a DARDR or a CSPR, where learning overlaps across systems.

In these situation:

- The review findings will benefit all involved areas, not just the lead SAB.
- Costs for commissioning an Independent Reviewer, administrative support, and stakeholder engagement are significant. Sharing these costs ensures equity, avoids duplication, and promotes collaborative learning.

Best Guidance for Agreeing Funding

There is no single statutory formula, but best practice is drawn from:

- Care Act 2014 Guidance (Chapter 14 – Safeguarding Adults Reviews).
- Local Safeguarding Partnerships protocols for multi-agency reviews.
- Principles of fairness and proportionality: funding should reflect the level of involvement and benefit for each SAB.

Recommended approach:

Early Discussion - Before the review starts, the lead SAB (this is usually where the adult has died but could vary when there are multiple areas involved) should convene a meeting with all relevant SABs and/or review partners.

Agree Proportional Contribution
Options include:

  - Equal split among SABs.
  - Proportional split based on involvement (e.g., number of agencies from each area, complexity of local factors).

Document Agreement - Record the funding arrangement in writing, signed off by all parties.

Practical Steps to Arrange Funding

- **Lead SAB drafts a proposal outlining:**
  - Estimated costs (Independent Reviewer, admin, publication).
  - Suggested funding model.

- **Circulate to partners for agreement.**
- If disagreement arises:
  - Escalate to Independent Chairs of the relevant SABs.
  - Chairs agree a final position based on statutory duties and partnership principles.
- Formalise via Memorandum of Understanding (MoU) or email confirmation.
- Set up invoicing arrangements through finance teams of one or each SAB.

Escalation Protocol

If mutual agreement cannot be reached:

- Independent Chairs should meet (or hold a virtual discussion).
- Decision should be based on:
  - Statutory responsibility (Care Act duty to arrange SAR).
  - Shared learning imperative.
- Document the decision and rationale for transparency.

36. Care Leavers and Duty of Notification

When a care leaver dies before their 25th birthday, there is a statutory duty to notify the relevant local authority. (The relevant children's service should notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. **Report the death or serious harm of a child or care leaver - GOV.UK**.)

This responsibility ensures that the circumstances surrounding the death are understood and that any safeguarding concerns are appropriately considered. In some cases, the criteria for a Safeguarding Adult Review (SAR) may be met, particularly where agencies had ongoing involvement or opportunities for intervention, or if no adults

services were involved with the individual but it appears that this may have been because there were barriers to effective transition planning for adulthood.

This section explores the link between the duty of notification and SAR processes, highlighting how timely information sharing and coordinated responses can support learning and improve outcomes for care-experienced young adults.

Care leavers aged 18–25 may qualify as adults with care and support needs, especially if they:

- Have mental health issues.
- Are homeless or at risk of exploitation.
- Have disabilities or concerns relating to substance misuse/addiction.

Overlap with Children's Safeguarding

In some situations, a **joint review** might be appropriate, involving both the **Safeguarding Adults Board (SAB)** and the **Children's Partnership**. However, it is important to remember if the Section 44 mandatory or discretionary criteria are met, it is the SAB that must commission the SAR.

Why a SAR Might Be Appropriate for Care Leavers

- **Transition vulnerabilities**: Many care leavers face challenges moving from children's to adult services, which can lead to gaps in support.
- **Complex needs**: Care leavers often have multiple, intersecting needs that require coordinated multi-agency responses.
- **Learning opportunity**: A SAR can help identify systemic issues in transition planning, service provision, and inter-agency communication for both children and adult services across the partnership.

Best Practice: A **joint SAR/CSPR** or coordinated review process can*:*

[SCIE, Quality Markers 8: Parallel Processes]

- Avoid duplication.
- Ensure a holistic understanding of the young person's journey.
- Promote shared learning across children's and adults' services.
- Ensure that terms of reference are agreed and that all relevant agencies are engaged in the SAR process at an early stage.

37. The role of Care Quality Commission (CQC) in SARs

The Care Quality Commission (CQC) has an important role in safeguarding and in supporting Safeguarding Adult Reviews (SARs), although it does not commission or conduct them. Its role includes:

Monitoring and Oversight

- Checks how well providers and local authorities meet safeguarding duties.
- Reviews whether learning from SARs is improving care quality and safety.
- During inspections, considers how organisations have acted on SAR findings.

Information Sharing

- Shares relevant intelligence with Safeguarding Adults Boards (SABs).
- May provide evidence to SARs where it has inspected or regulated the services involved.

System Learning and Improvement

- Uses SAR learning to inform its regulatory approach and national analysis.
- Expects providers to show how they have embedded SAR learning into practice.

Accountability and Challenge

- Can require improvements or take enforcement action where SARs highlight failings.
- Ensures providers are held accountable for safeguarding shortcomings.

Key Guidance

- SCIE provides tools and checklists to support effective SARs, emphasising:
  - A focus on learning.
  - Inclusion of practitioner voices.
  - Using review models suited to the circumstances of the adult.

38. Local SAB's Responsibilities in Reporting SARs

Under the **Care Act 2014 (Schedule 2, Section 4)** and **Care and Support Statutory Guidance (para. 14.177)**, Safeguarding Adults Boards (SABs) have a legal duty to ensure **transparency and accountability** in how Safeguarding Adult Reviews (SARs) are conducted, reported, and shared.

Annual Reporting Requirement

SABs must include in their annual report:

- Findings from any SARs completed during the reporting year.
- Details of SARs that are ongoing, including their scope and progress.
- A summary of actions taken in response to SAR findings, including how learning has been disseminated and embedded across partner agencies.

Purpose of Reporting

This statutory duty aims to:

- Promote transparency in local safeguarding governance.
- Strengthen multi-agency accountability.
- Ensure learning is shared widely to improve practice and prevent future harm.

Content Expectations

The annual report should:

- Clearly set out the themes and learning emerging from SARs.

- Describe the impact of SARs on policy, practice, and service delivery.
- Provide evidence of multi-agency engagement in implementing recommendations.
- Reflect on systemic issues and the steps being taken to address them.

Accessibility and Communication
SABs should ensure their annual report is:

- Accessible to the public, including adults with care and support needs and their families.
- Written in clear, jargon-free language wherever possible.
- Shared with local and regional partners (e.g., NHS, police, housing, voluntary sector).

Link to Strategic Planning
SAR findings should directly inform:

- The SAB's strategic plan and priorities for the coming year.
- The development of training, policy revisions, and quality assurance processes.

39. National Library of SARs

Post-Publication Action: National Library Submission

To support national learning, transparency, and the continued development of a robust evidence base for safeguarding practice, Safeguarding Adults Boards (SABs) are strongly encouraged to contribute to the National Network SAR Library. The most recent SAR analysis highlights an improvement priority for all SABs: *the National Network for SAB Chairs and the National Network of SAB Business Managers should continue to promote the SAR Library, and all SABs should routinely consider submitting their completed SARs to ensure their local learning contributes to a lasting national repository.*

In line with this priority, **following publication of any Safeguarding Adult Review (SAR) on the local SAB website, local SAB's should ensure that the SAR is submitted to the National Library**. This enables wider sector learning, supports national thematic analysis, and strengthens transparency and accountability across safeguarding systems.

To facilitate this, please ensure that the **National SAR Referral Form** is fully completed and submitted to **michael.preston-shoot@beds.ac.uk**. This will allow the SAR to be appropriately logged and uploaded to the National SAR Library hosted at nationalnetwork.org.uk.

40. Conclusion

In summary, maintaining an effective Safeguarding Adult Review (SAR) process requires ongoing reflection, collaboration, and a commitment to continuous improvement. As safeguarding landscapes, national expectations, and multi-agency practices evolve, it is good practice for every Safeguarding Adults Board (SAB) to keep its SAR policy and procedures under regular review.

This guidance is designed not only to support consistent and informed decision-making but also to act as a practical resource tool for partners. SABs are encouraged to use it actively in their work, recognising that it will be kept under review and updated to reflect emerging learning, national priorities, and developments in safeguarding practice.

By routinely reflecting on the effectiveness of local arrangements, SABs can ensure that their approach remains responsive, proportionate, and rooted in trauma-informed, person-centred principles. Regular review also assists Boards in embedding learning from previous SARs, aligning with wider national themes, and strengthening partnership collaboration.

Through this continuous cycle of learning, adaptation, and improvement — supported by an evolving and reliable resource — SABs can be confident that their SAR arrangements remain robust, transparent, and fit for purpose. Ultimately, this commitment enhances local and national safeguarding systems and improves outcomes for adults at risk.