



**Bracknell Forest**  
SAFEGUARDING BOARD

# **Safeguarding Adults Review (SAR) Framework**

**This document sets out how to request and conduct Safeguarding  
Adults Reviews in Bracknell Forest**

***(under Section 44 of the Care Act 2014)***

<b>Version:</b>	Final
<b>Effective:</b>	September 2019
<b>Review Date:</b>	September 2020

# Safeguarding Adults Review Framework

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# 1. Introduction

- 1.1 [Section 44 of the Care Act 2014](#) and associated statutory guidance require Safeguarding Adults Boards (SAFEGUARDING BOARD) to conduct Safeguarding Adults Reviews (SARs) in certain circumstances, and permits the Safeguarding Board to arrange SARs in other circumstances. The Act requires Safeguarding Board member agencies to cooperate with and contribute to the carrying out of a SAR.
- 1.2 The purpose and underpinning principles of SARs, and the broad requirements and guidance for conducting SARs, are set out in section 2.9 of the [Berkshire Multi-agency Adult Safeguarding Policy](#). These policy and procedures have been adopted by the Bracknell Forest Safeguarding Board and provide the overall governance of our SAR approach.
- 1.3 This SAR framework for the Bracknell Forest Safeguarding Board must be read in conjunction with them.
- 1.4 This framework has drawn on the Camden Safeguarding Adults Review framework as well as drawing directly on the statutory guidance and the Berkshire multi-agency policy and procedures.
- 1.5 The following in sections 1-6 are taken from the Care and Support Statutory Guidance<sup>1</sup> and sets out the circumstances in which a SAR will be undertaken; the purpose of the SAR and the underlying principles in carrying out SARs.
- 1.6 It is important to note that any agency can notify the Safeguarding Board (SB) of a serious incident they think should be considered for a Safeguarding Adult Review (SAR). However, this process can also be used where cases do not meet these criteria but appear to offer an opportunity for learning in respect of multi-agency working using alternative methodology (see section 9.2.2). In all cases a Rapid Review (RR) will be undertaken to determine the most appropriate response.

## 2. When should the Safeguarding Board arrange a SAR and links with other review processes

- 2.1 Safeguarding Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- 2.2 Safeguarding Boards must also arrange a SAR if an adult in its area has not died, but the Safeguarding Board knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. Safeguarding Boards are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.
- 2.3 The Safeguarding Board should primarily be concerned with assessing what type of 'review' process will promote effective learning and improve actions to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.
- 2.4 When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a Child Serious Practice Review (CSPR) and a Domestic Homicide Review (DHR).

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<sup>1</sup> Care and Support Statutory Guidance issued under the Care Act, 2014, paragraphs 14.133 to 14.149  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)

Where such reviews may be relevant to SAR (e.g. because they concern the same perpetrator), consideration should be given to how SARs, DHRs and CSPRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case - for example, considering whether some aspects of the reviews can be commissioned jointly to reduce duplication of work for the organisations involved.

- 2.5 In setting up a SAR, the Safeguarding Board should also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a CSPR or DHR, a criminal investigation or an inquest.
- 2.6 It may be helpful when running a SAR and DHR or CSPR in parallel to establish at the outset all the relevant areas that need to be addressed, to reduce potential for duplication for families and staff. Any SAR will need to take account of a coroner's inquiry, and/or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process. It will be the responsibility of the Chair of the SAR Panel to ensure contact is made with the Chair of any parallel process in order to minimise avoidable duplication.

### **3. What is the purpose of a SAR?**

- 3.1 SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

### **4. What are the guiding principles for a SAR?**

- 4.1 The following principles should be applied by Safeguarding Boards 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 serious cases should be Chaired/led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
  - Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
  - Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively
- 4.2 SARs should reflect the six safeguarding principles. Safeguarding Boards should agree Terms of Reference (ToR) for any SAR they arrange and these should be published and openly available. When publishing SARs the records should be anonymised and (if applicable) redacted, or consent should be sought.
- 4.3 Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR does not need to be, or have been, in receipt of care and support services for the Safeguarding Board to arrange a review in relation to them.

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

## 5. Process: key issues

- 5.1 The process for undertaking SARs should be determined locally according to the specific individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the Safeguarding Board.
- 5.2 The Safeguarding Board should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR Panel should also communicate with the adult and/or their family. In some cases it may be helpful to communicate with the person who caused the abuse or neglect.
- 5.3 It is expected that those undertaking a SAR will have appropriate skills and experience which should include:
- Strong leadership and ability to motivate others
  - Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
  - Collaborative problem-solving experience and knowledge of participative approaches
  - Good analytic skills and ability to manage qualitative data
  - Safeguarding knowledge
  - Inclined towards promoting an open, reflective learning culture
- 5.4 The Safeguarding Board should aim for completion of a SAR within a reasonable period of time (and in any event within six months of initiating it), unless there are good reasons for a longer period being required - 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 case about improvements needed and to take corrective action.

## 6. Information sharing

- 6.1 A Safeguarding Board may request a person to supply information to it or to another person. The person who receives the request must provide the information provided to the Safeguarding Board if:
- the request is made in order to enable or assist the Safeguarding Board to do its job
  - the request is made of a person who is likely to have relevant information and then either:
    - the information requested relates to the person to whom the request is made and their functions or activities or
    - the information requested has already been supplied to another person subject to a Safeguarding Board request for information. (paragraph 14.156 statutory guidance.)

## 7. The Findings from SARs

- 7.1 The Safeguarding Board should include the findings from any SAR in its Annual Report and what actions it has taken, or intends to take, in relation to those findings. Where the Safeguarding Board decides not to implement an action then it must state the reason for that decision in the Annual Report. All documentation the Safeguarding Board receives from registered providers which is relevant to the CQC's regulatory functions will be provided to the CQC.

- 7.2 SAR reports should:
- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible
  - Be written in plain English
  - Contain findings of practical value to organisations and professionals

## 8. The Adult Safeguarding Multi-Agency Policy and Procedures

8.1 The procedures<sup>2</sup> adopted in Bracknell Forest underline the following in addition to / support of the above statutory guidance:

### 8.1.1 Boards requiring information for SARs

There is an expectation that individuals, agencies, and organisations will cooperate with the review, but the Act also gives Boards the power to require information from relevant parties.

### 8.1.2 Criminal investigations and police involvement

Where there is an ongoing criminal investigation or criminal proceedings, the Safeguarding Board will need to consider, in consultation with the police, whether continuing with the SAR might prejudice their outcome and whether the completion of the SAR should be postponed until after the criminal investigation or proceedings have been completed.

### 8.1.3 Keeping the adult and / or their family / relevant others central to the SAR process

In non-fatal cases, the views of the adult should be central to the decision-making process about the type of SAR to undertake. Communication should be established at the earliest opportunity and advocacy provided to support the adult.

The desired outcome, especially where a family is bereaved, needs to be approached with sensitivity. Consultation and involvement needs to be balanced with the overall wellbeing of the individuals involved. Throughout the process due diligence, compassion and appropriate support should be provided and the support of relevant local authority community team should be available to provide this or an alternative arranged if more appropriate.

### 8.1.4 Advocacy

The local authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a SAR. Where the adult is deceased, it is good practice to provide advocacy to family / friends.

### 8.1.5 Staff involved in informing SARs

All professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. Where an adult has died, professionals working with that adult should have the opportunity to discuss their feelings in a safe environment and offered counselling or other therapeutic support. Professional supervision may not be the most helpful means of exploring any fears or anxieties or coping mechanisms to enable professionals to take an objective view and learn from the SAR. There will be occasions when allegations are made that staff have been guilty of abuse against adults at risk.

- If the staff member is subject to a criminal investigation, consideration will need to be given to the timing of any SAR.
- If the staff member is subject to a disciplinary enquiry, it is likely that the SAR will work alongside the disciplinary enquiry.

### 8.1.6 Process issues

Individuals commissioned to undertake a SAR must be independent of the organisations involved.

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<sup>2</sup> <http://www.SafeguardingBoardberkshirerwest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/>

No one model<sup>3</sup> of review will be applicable to all cases. The focus must be on what needs to happen to achieve understanding, take remedial action and, very often, provide answers for families and friends of adults who have died or been seriously abused or neglected. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed and to take corrective action.

#### 8.1.7 First steps in taking a SAR forward:

- Identify a SAR Chair/Lead to coordinate arrangements
- Determine a model for the review (appropriate/proportionate)
- When commissioning a SAR the following points should be agreed:
  - Scope of the terms of reference
  - Knowledge, skills and experience of the reviewer
  - Timescales for completion
  - Who will secure any legal advice required
  - How the interface between the SAR and any other investigations or reviews will be managed
  - A communication strategy, including clarification about what information can be shared, when and where (conditions)
  - A media strategy
  - What the arrangements for administrative and professional support are
  - How it will be paid for

Consideration of other reviews / investigations is covered above in the statutory guidance.

#### 8.1.8 Coroners

A SAR may need to take account of a Coroner's inquiry, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay. Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home)
- Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries / actions are identified by the Coroner or his or her officers

In the above situations the local Safeguarding Board should give serious consideration to initiating a SAR.

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<sup>3</sup> A range of models for approaching SARs is set out in the SCIE guide <http://www.scie.org.uk/care-act-2014/safeguarding-adults/reviews/> *Safeguarding Adults Reviews under the Care Act: implementation support* (SCIE 2015).

## 9. A framework for taking forward cases that may require consideration under a SAR

### 9.1 Requesting a SAR

- 9.1.1 The Bracknell Forest Safeguarding Board is the only body that may commission SARs of adult safeguarding cases in Bracknell Forest.
- 9.1.2 Any agency, professional or individual can use the process outlined below to request a SAR on a case believed to fit the criteria listed in [section 2](#). A flowchart of the process is available at [Appendix 1 and 1b](#).
- 9.1.3 A case may come to notice due to (for example but not limited to): an individual worker/ volunteer notifying a manager; a serious incident or accident report; a complaint or whistle-blower; a Section 42 safeguarding enquiry; notification from the Care Quality Commission (CQC) or any other channel.
- 9.1.4 Where a professional or volunteer working for an agency is requesting a SAR, the request should first go through their organisation's appropriate management structure. The organisation's relevant senior manager and / or representative on the Safeguarding Board will then make the SAR request to the Safeguarding Board c/o the Business Unit. To ensure the efficient identification of appropriate cases for SAR consideration, relevant operational managers in agencies need to be aware of the criteria for a SAR.
- 9.1.5 If the incident triggers a mandatory investigation or review within the organisation concerned (e.g. NHS SIRI) this should take place as a matter of priority, but a referral for a SAR (if appropriate) should not be delayed and should be made at the same time. Internal governance processes and multi-agency reviews are not mutually exclusive.
- 9.1.6 Requests for a SAR must be made in writing using the SAR request form (see [Appendix 2a](#)), which should be completed as fully as possible. The request must be sent to the Safeguarding Board Business Unit, with a copy to the Director of Adult Services by either secure email or post to protect personal and / or sensitive information. The Business Unit will collect additional information using the Request for information form ([see Appendix 2b](#)), convene a special meeting of designated Safeguarding Board members for a decision on whether to proceed with a SAR. If it is felt that additional information is needed to assist the Board in making a decision this will be requested.
- 9.1.7 The designated Safeguarding Board members will meet to review the request and decide whether the criteria for a SAR have been met ([see section 2](#) and [section 9.2](#)) and, if required, to decide which SAR methodology should be used ([section 9.3](#)). This may be delegated to the Case Review Sub Group to decide. The Independent Chair and Scrutineer will be informed of the decision to conduct a SAR.
- 9.1.8 The Business Unit, on behalf of the Board, will write to the requestor and relevant statutory Director(s) to inform them of the outcome of the SAR request and reasons for the decision (see template letter A at [Appendix 4](#)).
- 9.1.9 If a request for a SAR is upheld the Business Unit, on behalf of the Board, will write to the Chief Executives (or equivalent) of all relevant agencies, copied to their respective Board member, to notify them of the decision to commission a SAR and the methodology to be used (standard letter B at Appendix 3). Chief executives (or equivalent) are to make the necessary arrangements for participation in the SAR, e.g. securing files and records; nominating a representative for a SAR Panel. The Business Unit will also arrange for relevant commissioning and regulatory bodies to be notified that a SAR has been initiated.
- 9.1.10 If a request for a SAR is turned down, and where the requestor is dissatisfied with this outcome, they should notify the Chair of the Bracknell Forest Safeguarding Board in writing, who will discuss and review (if necessary) the decision with the requestor and the panel of Board members who decided on the initial request.
- 9.1.11 If a decision not to hold a SAR is upheld, the requesting agency can choose to take no further action or to undertake an internal review using an appropriate methodology (some options are set out in the Berkshire



Multi-Agency Safeguarding Adults Policy and Procedures). All relevant organisations must continue to implement any actions in the protection plan from any original Section 42 safeguarding enquiry.

## 9.2 Making decisions on SAR requests

- 9.2.1 In deciding whether a SAR should be conducted, the Safeguarding Board must first consider whether there is a statutory obligation to undertake a SAR: whether the request meets the criteria outlined in [section 2](#). A SAR must be commissioned if there is a statutory requirement to do so.
- 9.2.2 In cases other than those involving a statutory obligation, the subgroup should carefully consider whether commissioning a non-statutory SAR would be a valuable exercise: i.e. whether or not a multi-agency review process has the potential to identify sufficient lessons to enhance partnership working, improve outcomes for adults and families and prevent similar abuse and neglect in the future. It is vital that the intensive resources required for a SAR are focussed on those cases that will yield the greatest learning and practice development.
- 9.2.3 Considering the following questions may help to establish whether there are sufficient lessons to be learned and value in commissioning a non-statutory SAR:
- Was there a “near miss”?
  - Does the case indicate that there may be failings in how the adult safeguarding multi-agency policies and procedures function, leading to serious concerns about how professionals/services work together?
  - Did the system not recognise / share evidence of risk of significant harm to an adult or recognise / share it late?
  - Is there evidence that system conditions lead to poor multi-agency working or communication?
  - Does the case involve serious or systemic organisational abuse and multiple alleged perpetrators, from which learning could be transferred to other organisations to prevent such abuse or neglect in the future?
  - Could the case potentially yield systems learning around how agencies work together to prevent and reduce abuse and neglect that would help to do things differently in the future?
  - Would a SAR enable the Safeguarding Board to be proactive and pre-emptively tackle practice areas or issues before harm arises?
  - Does intelligence from other quality assurance and feedback sources (e.g. audits / complaints) suggest that the kind of issue in the case is new, complex or repetitive and that conducting a SAR would therefore be beneficial?
  - Has this happened before (in Bracknell Forest or elsewhere) and was a SAR commissioned then?
  - Has the learning from any previous SAR been implemented or is there new learning to be identified?
  - Is there, or is there likely to be, media interest or serious public concern?
  - Is there evidence of sufficient good practice that could be shared across the partnership to the benefit of adults and their families?
- 9.2.4 The Board should also consider whether another review or learning process has already been commenced that will identify and share lessons to be learned, or which the Bracknell Forest Safeguarding Board could potentially feed into / from to avoid duplication (e.g. Domestic Homicide Review or health SIRI).
- 9.2.5 In deciding to commission a SAR the Bracknell Forest Safeguarding Board should aim for consensus, not a majority view. If the subgroup cannot come to a consensus, the final decision will rest with the Independent Chair and Scrutineer after carefully considering the views of all panel members.
- 9.2.6 If the decision whether to proceed with a SAR is unclear the Chair of the Bracknell Forest Safeguarding Board may be consulted and the Chair may discuss this with a fellow Safeguarding Board Chair to obtain a peer view to refer back to the Safeguarding Board.

## 9.3. Making a decision on SAR methodology

9.3.1 Once the Safeguarding Board has agreed to commission a SAR, they must decide on the most appropriate methodology to use (See [Appendix 3](#)). Alternatively this may be delegated to the Case Review sub group. How the SAR is conducted will affect the kind of learning obtained from it and whether the process is constructive and valuable. The choice of methodology is therefore significant. In selecting a review methodology the following principles need to be considered:

- It is about learning, not holding to account
  - Independence
  - Trust/open and honest/ transparency/sharing information
  - Involving the person and/or their family
  - Involving and supporting staff/professionals involved at the time
  - Making sure the learning produces real outcomes in practice for people
  - Reflecting the 6 safeguarding principles (Care & Support Statutory Guidance)
  - Flexibility of approach/proportionate approaches
  - Answers for family/friends of those who have died/or been harmed
  - Openly published where appropriate
  - Timeliness - completed in 6 months from decision to hold review (unless -and give reasons)
- (Based on statutory guidance & Berkshire procedures)*

The following are helpful elements of review approaches:

- Involvement of both frontline staff/senior managers, securing both strategic and operational perspectives
- Including perspective of staff involved in the case, reflective of systems operating at the time
- Consideration of system and practice strengths as well as weaknesses
- Learning takes place throughout the process enhancing commitment to its dissemination
- Partnership working: including mutual recognition of alternative partner perspectives and collaborative problem solving

*(Based on London SAPBs 2012). [Serious Safeguarding Adults Reviews: Guidance note on options for London](#) (cited in SCIE guide 2015)*

The Care Act statutory guidance indicates that, whichever SAR methodology is employed, the following elements should be in place:

- 9.3.2 **SAR Chair** – independent of the case under review and of the organisations whose actions are being reviewed, with appropriate skills, knowledge and experience:
- Strong leadership and ability to motivate others
  - Ability to handle multiple competing perspectives and potentially sensitive/ complex group dynamics
  - Good analytical skills using qualitative information
  - A participative and collaborative approach to problem solving
  - Adult safeguarding knowledge
  - Commitment to/ promotion of open and reflective learning cultures
- 9.3.3 **SAR Panel** – scrutinises information submitted to the review and shapes the independent report. The panel membership should be proportionate to the nature and complexity of the review but should comprise a minimum of three members and a support officer in addition to a Chair with a level of independence from the case under review.
- 9.3.4 **Terms of reference** – published and openly available, reviewed annually. See [Appendix 5](#)

- 9.3.5 **Early discussions with the adult and their family, carers and friends** – to agree to what extent and how they would like to be involved in the SAR, and to manage expectations. This includes access to independent advocacy if required (to be provided by the Local Authority).
- 9.3.6 **Appropriate involvement of professionals and organisations who were working with the adult** – to contribute their perspectives without fear of being blamed for actions they took in good faith.
- 9.3.7 **SAR report and recommendations** – See [Appendix 6](#)
- 9.3.8 Outside of these requirements, the methodology employed should be determined by and proportionate to the specific circumstances of the individual case. This implies Safeguarding Boards need a range of review options to match against different cases.
- 9.3.9 The methodology selected must offer the most effective learning and involvement of key staff/ family weighed against the cost, resources and length of time required to conduct the review.
- 9.3.10 The following should be considered in selecting a SAR methodology:
- Is the case complex, involving multiple abuse types and/or victims?
  - Is significant public interest in the review anticipated?
  - Is large scale staff/family involvement required and/or appropriate?
  - Are any criminal proceedings ongoing that staff could be witnesses in, and could the SAR methodology impact on them?
  - Is the type of review being suggested proportionate to the scale and level of complexity of the issues being examined?
  - What is the quickest and simplest way to identify the learning?
  - Is a more appreciative approach required to review good practice?
  - Are trained lead reviewers available in-house or nationally for the method selected?
  - Are resources available to train or commission a lead reviewer?
  - Can value for money be demonstrated?
- 9.3.11 In selecting an SAR methodology the Bracknell Forest Safeguarding Board designated members (or Case Review sub group if delegated) should aim for consensus, not a majority view. If a consensus cannot be reached, the final decision will rest with the Chair of the Bracknell Forest Safeguarding Board after carefully considering the all the views.
- 9.3.12 In addition to selecting a SAR methodology, the designated members of the safeguarding board (or case review sub group if delegated) must also decide:
- Which agencies should be asked to participate in the SAR Panel?
  - Level of independence from the case required of panel members (it is advisable that panel members have not had involvement in the case nor line management responsibility for staff writing a report for the SAR)
  - Whether agencies should be required to secure their files/records
  - Level of independence required of the SAR chair (e.g. representative from another agency, external consultant etc.)
  - The final detail of the Terms of Reference for the SAR will be determined by the SAR Panel. This will build on areas for inclusion as determined by the Case Review Subgroup and Safeguarding Board. The ToR will include timescales for completion and how learning from the SAR will be disseminated and embedded.
  - The required output from the SAR (e.g. a report, findings, recommendations)
  - Whether an independent author is required and level of independence. If so, the Safeguarding Board will appoint an independent author.

## 9.4 Options for SAR methodology

9.4.1 The selection of a methodology will take into account above considerations and make reference to the body of experience across safeguarding partnership. A range of models for approaching SARs is set out in the SCIE guide [Safeguarding Adults Reviews under the Care Act: implementation support](#) (SCIE 2015). [See Appendix 3](#)

The designated members of the Bracknell Forest Safeguarding Board (or Case Review sub group if delegated) may decide upon another methodology that reflects the principles set out in this framework and the statutory guidance.

## 9.5 Conducting the SAR

9.5.1 If the SAR request is agreed, the Chair of the Bracknell Forest Safeguarding Board Case Review Subgroup will invite the preferred candidate(s) to chair the SAR Panel, and brief them on the agreed methodology, terms of reference (as identified to date by the panel) and required timescales.

9.5.2 A multi-agency SAR Panel will be set up in line with the methodology and any requirements set by the designated members of the Safeguarding Board who reviewed the SAR request (see paragraph 5.6).

9.5.3 The Chair of the SAR Panel (with support from the Business Unit) is responsible for:

- Setting SAR Panel meeting dates and agendas as required
- Ensuring the ToR reflect any emerging issues identified early on
- Inviting all nominated representatives from relevant agencies to SAR Panel meetings
- Ensuring the review is conducted according to the terms of reference and methodology
- Ensuring a satisfactory report and executive summary are agreed by the panel
- Notifying the Bracknell Forest Safeguarding Board of any shortfall in administrative/ resourcing arrangements
- On-going liaison with the police and/or coroner's office as required
- Arranging early discussions with the adult(s) and their family/representatives [if appropriate] and requesting the arrangement of any support they require to participate
- Initiating the preparation and implementation of media and communication strategies as necessary, or the obtaining of legal advice
- Requesting any data / evidence / reports from partner agencies as required

## 9.6 Adult / family involvement and independent advocacy

9.6.1 This section must be read in conjunction with the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures, and Section 68 of the Care Act and associated statutory guidance.

9.6.2 Adults and / or families should be invited and supported to contribute to SARs if they wish to do so, in order that an inclusive approach is taken and that their wishes, feelings and needs are placed at the heart of the review.

9.6.3 The SAR Panel chair must attempt to contact the adult(s), their family and / or representatives as appropriate early in the process (ideally before the first SAR Panel meeting) to establish:

- Why and how a SAR will be undertaken into their (family member's) case
- How they would like to be involved – e.g. views contributed via telephone conversation, or interview, or attendance at SAR meetings
- Any support or adjustments they would need to facilitate their involvement
- Their initial views, wishes, concerns, and any answers / outcomes they would like to achieve from the SAR

- 9.6.4 Reasonable and appropriate support and adjustments should be made by the Bracknell Forest Safeguarding Board as required to enable the adult(s), their family and/or representatives to participate in the SAR.
- 9.6.5 If there is no appropriate person to support and represent the adult(s) and this is deemed necessary/desirable, then Bracknell Forest Council must arrange for an independent advocate (under [Section 68 of the Care Act](#)).
- 9.6.6 Alternatively, if the relevant criteria are met, appropriate partners can arrange for an independent mental capacity advocate (IMCA) or an Independent Mental Health Advocate (IMHA) to support and represent the adult(s). If an independent advocate, IMCA or IMHA has already been arranged for the adult(s), e.g. during assessment and care support planning or for a safeguarding enquiry, then the same advocate should continue to be used.
- 9.6.7 It is for Bracknell Forest Council to form a judgement on a case by case basis about whether the adult(s) has “substantial difficulty” in being involved in the SAR process and about who can act as an appropriate person.

## 9.7 Staff involvement

- 9.7.1 This section must be read in conjunction with the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures.
- 9.7.2 As soon as a SAR has been agreed, staff and volunteers who have been involved in the case should be notified of the decision by their agency. The nature, scope and timescale of the review should be made clear at the earliest possible stage to staff, volunteers and their line managers.
- 9.7.3 It is important that relevant staff and volunteers of all agencies are given an opportunity to share their views on the case as appropriate to the review methodology selected. This may be as part of the IMR process. This should include their views about what, in their opinion, could have made a difference for the adult(s) and/or family. All agencies must support staff and practitioners involved in a SAR to “tell it like it is”, without fear of retribution, so that real learning and improvement can happen.
- 9.7.4 Agencies are responsible for ensuring their own staff and volunteers are provided with a safe environment to discuss their feelings and offering support where needed. The death or serious injury of an adult at risk will have an impact on staff and volunteers and needs to be acknowledged by the agency. The impact may be felt beyond the individual staff and volunteers involved, to the team, organisation or workplace.

## 9.8 Professional conduct issues arising

- 9.8.1 This section must be read in conjunction with the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures.
- 9.8.2 The purpose of a SAR is not to apportion blame to an individual or an agency but to learn lessons for future practice. It is important that this message is conveyed to staff and volunteers. Issues of professional conduct may become apparent during a SAR, but it is not within the remit of the SAR Panel to deal with these.
- 9.8.3 Where concerns about an individual’s practice or professional conduct are raised through the SAR process, they must be fed back to the relevant agency through the SAR Panel chair. It then remains the responsibility of the individual agency to trigger any action in proportion with the concerns passed on by the SAR Panel.

## 9.9 SAR reports

- 9.9.1 This section must be read in conjunction with the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures which are to be adopted / adapted by the Bracknell Forest Safeguarding Board.
- 9.9.2 The required output of a SAR – e.g. whether a report is needed, and / or independent authorship – is to be set out in the SAR terms of reference as agreed by the Case Review Subgroup and the Safeguarding Board

- 9.9.3 The SAR Panel Chair must ensure that there is sufficient discursive analysis, scrutiny and evaluation of evidence by the SAR Panel throughout the SAR process. The systemic and contributory factors, practice and procedural issues and key learning points identified by the SAR Panel should form the basis of any SAR report, to be produced by the nominated author.
- 8.9.4 A template SAR report is provided at [Appendix 6](#)
- 9.9.5 The Case Review Subgroup should receive and agree the draft report before it is presented to the Bracknell Forest Safeguarding Board so that all agencies are satisfied the panel's analysis and conclusions have been fully and fairly represented.
- 9.9.6 The adult(s) and/or family should also be given the opportunity to discuss the SAR report and conclusions, and their experience of the process.
- 9.9.7 The Case Review Subgroup will decide to whom the SAR report, in whole or in part should be made available and the means by which this will be done. This should include publication via the Bracknell Forest Safeguarding Board webpages but could also include dissemination via the Knowledge Hub and / or regional networks. Considerations of reputational risk or national learning arising from the case may affect decisions to publish. Any reports to be published must be fully anonymised.
- 9.9.8 The Safeguarding Board Business Manager (or equivalent) will make appropriate arrangements for the SAR report and other records collected or created as part of the SAR process to be held securely and confidentially for an appropriate period of time in line with the Bracknell Forest Safeguarding Board's information sharing agreements, the Data Protection Act and other legal requirements.

## 9.10 Quality assurance of the SAR

- 9.10.1 Quality assurance is embedded throughout the SAR process, from commissioning through to Safeguarding Board scrutiny of the report and implementation of recommendations. Quality assurance is also built into the SAR methodology options set out in this framework.
- 9.10.2 In each model it is imperative that SAR Panel members avoid agency defensiveness and arguments about minute detail of what happened. The following arrangements will help to avoid/ minimise this:
- Commissioning the most appropriate SAR methodology for the case
  - Commissioning a suitably skilled, experienced and independent SAR lead or chair to facilitate the review and analysis
  - Independence of SAR Panel members and IMR authors from the case under review
  - A focus in each model on seeking out causal factors and systems learning
  - Requirements in the terms of reference for the SAR to take a broad learning approach and to "tell it like it is"
- 9.10.3 Finally, the contents of the report presented to the Safeguarding Board (as set out in [Appendix 6](#)) must contain enough of the evidence, analytical techniques/ tools used and "working out" for the Safeguarding Board to be able to check, scrutinise and challenge. In doing so, the Safeguarding Board will gain assurance of the adequacy of the evidence, quality of the analysis and usefulness of the recommendations, but will not duplicate the work already completed in the course of the SAR.

## 9.11 Acting on the recommendations of the SAR

- 9.11.1 The Bracknell Forest Safeguarding Board will, through the Case Review Subgroup and with the support of the Business Manager, translate learning and recommendations from the SAR report into a multi-agency action plan if required, which should be endorsed at senior level by each organisation to whom it relates. The Board will seek assurance that individual agency action plans are carried through. The Safeguarding Board may decide not to implement a recommendation(s) but must state the reason for that decision in its Annual Report.

9.11.2 The multi-agency action plan will indicate:

- The actions that are needed
- Responsibilities for specific actions
- Timescales for completion of actions
- The intended outcomes: what will change as a result?
- Mechanisms for monitoring and reviewing intended improvements
- The processes for dissemination of the SAR report or its key findings

9.11.3 Individual agencies may also be asked by the Safeguarding Board to produce and implement their own internal action plans if required.

9.11.4 Board members of the Bracknell Forest Safeguarding Board are responsible for ensuring all actions are completed from their own and the multi-agency action plan, and for ensuring that learning from the SAR is embedded in their organisation and constituent agencies. However, agencies should make every effort to capture learning points and take internal improvement action where possible while the SAR is in progress, rather than waiting for the SAR report and action plan.

9.11.5 The Bracknell Forest Safeguarding Board will monitor progress on all multi-agency recommendations (or delegate to an appropriate subgroup) and may request periodic progress update reports from relevant agencies, until such time that all actions have been completed.

9.11.6 In line with Schedule 2 of the Care Act, the Bracknell Forest Safeguarding Board will include findings from any SARs in its Annual Report, together with information on any ongoing SARs. The Annual Report will list all completed SARs, what action was taken or is intended to be taken in relation to the findings, or where the Bracknell Forest Safeguarding Board decided not to implement a recommendation the reasons for that decision.

## 9.12 Applying learning from other SARs

9.12.1 The Bracknell Forest Safeguarding Board is committed to the regular analysis of the themes and learning from nationally high-profile SARs and relevant other SARs as selected by the Board Manager and Case Review Subgroup.

9.12.2 The Case Review subgroup has an embedded process for the review of SARs from outside the Bracknell Forest as part of their annual workplan to ensure lessons are identified, disseminated and embedded:

- The Safeguarding Board Business Manager will identify key themes and learning from SARs outside of the Bracknell Forest, and present summary details to the Subgroup following discussion with the chair
- The Subgroup will review the themes and learning in the Bracknell Forest context to evaluate learning and identify any areas for improvement for Bracknell Forest
- The SAR information is disseminated to partners via their subgroup member for identification and implementation of any single agency learning
- Relevant multi-agency learning and actions identified are drawn together and presented to the Safeguarding Board for discussion and consideration as part of the Safeguarding Board strategic plan.

9.12.3 The Case Review subgroup may do whatever else it deems necessary and reasonable to facilitate the dissemination and embedding of this learning into practice, e.g. facilitating a learning slot at a Safeguarding Board Meeting, circulating e-newsletters, incorporating findings into training and workshops for staff.

9.12.4 The East Berkshire Learning and Development subgroup will co-ordinate the wider dissemination and embedding of learning.

## 9.13 Supporting and resourcing SARs

9.13.1 Section 44(5) of the Care Act requires each member of the Bracknell Forest Safeguarding Board to co-operate in and contribute to the carrying out of a SAR, with a view to:

- Identifying the lessons to be learned from the case
- Applying those lessons to future cases.

9.13.2 Partners are required under [Sections 6](#) and [7](#) of the Care Act to:

- Co-operate in general in the performing of statutory functions under the Care Act that relate to protecting adults with needs for care and support (and/ or carers) from abuse and promoting their wellbeing, including SARs
- Co-operate when requested in relating to specific cases, such as SARs

9.13.3 In addition, [Section 45](#) of the Care Act places a duty on all partner organisations to supply information to the Bracknell Forest Safeguarding Board (or other specified person/body) where they are likely to have relevant information that will enable or assist the Safeguarding Board in exercising its functions – including conducting SARs.

9.13.4 Resources are needed for undertaking and supporting a SAR. The statutory partners of the Bracknell Forest Safeguarding Board will provide resources, in cash or kind, on a shared basis to ensure that the relevant costs for each SAR can be met. These will vary according to the methodology selected – e.g. a SAR requiring the services of consultants as independent chair and independent author will be more costly.

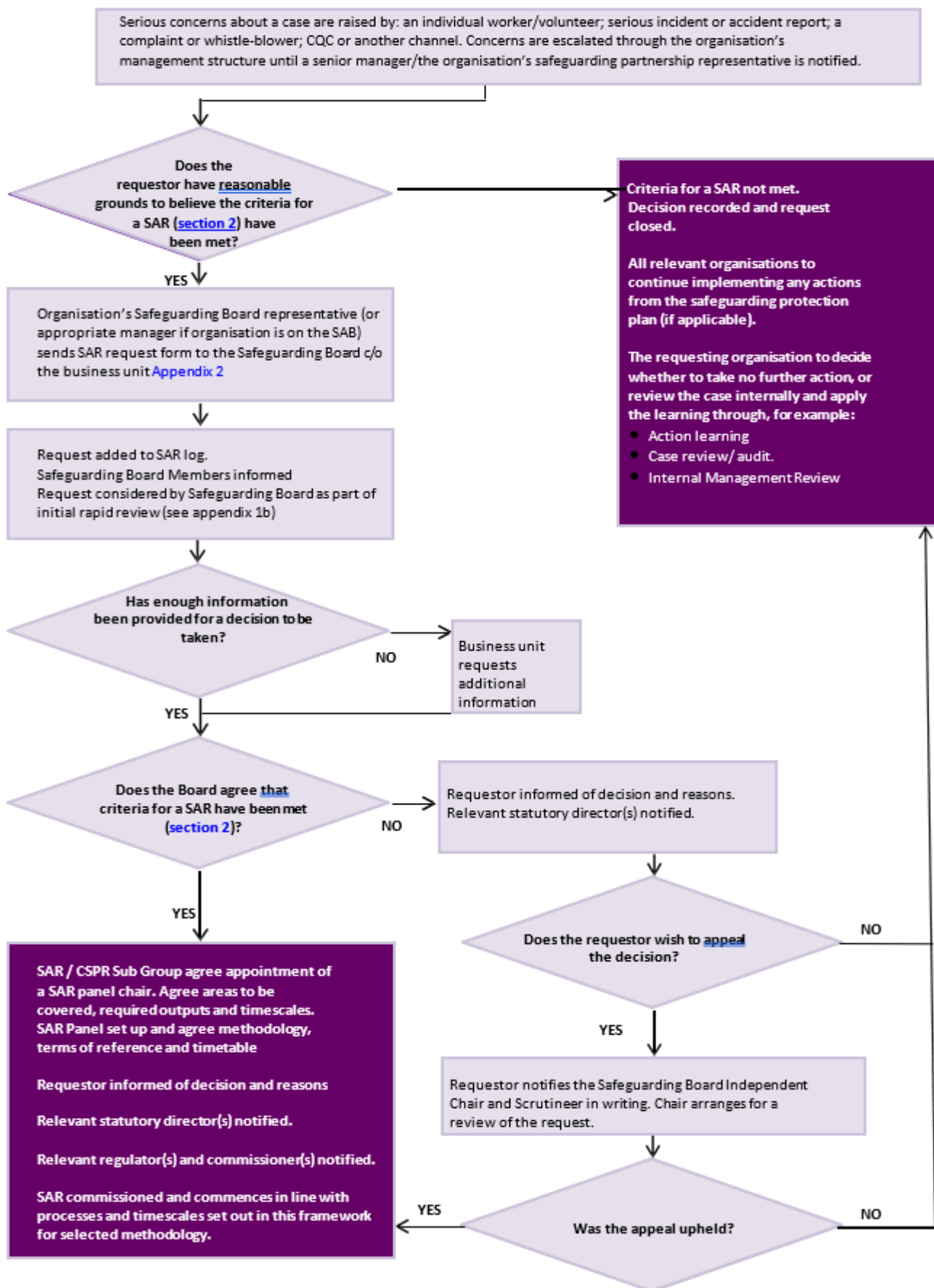
9.13.5 The statutory partners on the Bracknell Forest Safeguarding Board will also ensure that the SAR Chair and Panel receive adequate administrative support and will take a decision on how and from whom this will be provided.

9.13.6 All partners will commit internal resources to the production of evidence for a SAR (e.g. an IMR or interviews / conversations with relevant staff) as requested by the SAR Panel.

9.13.7 The Safeguarding Board Business Manager will maintain an annual overview of SAR related costs for the Safeguarding Board, for consideration each year as part of the Annual Report and to aid annual budgeting.

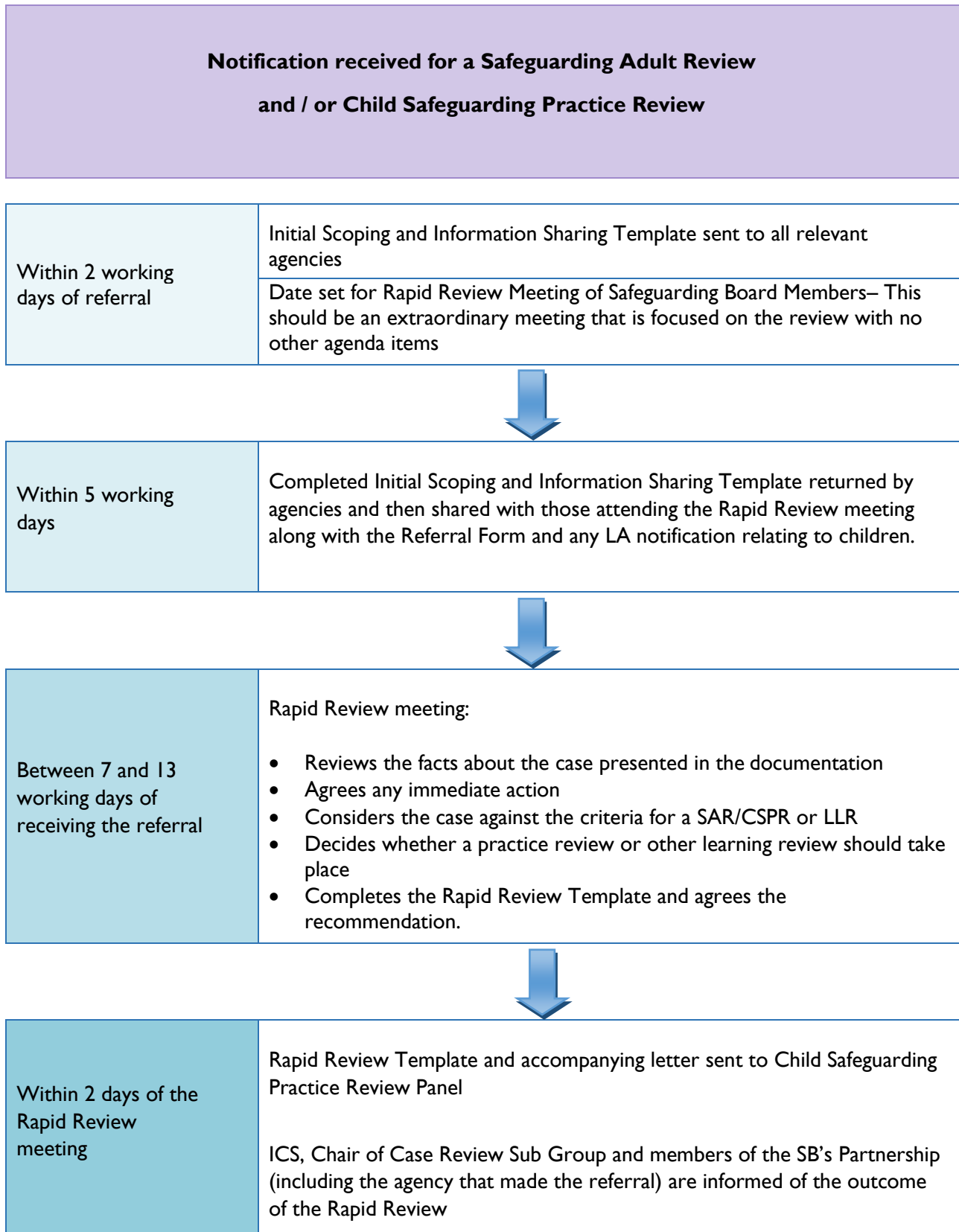


## Appendix 1a: Flowchart for request of a SAR



## Appendix 1b:

### Rapid Review Flowchart



## Appendix 2a: SBA 1 Bracknell Forest Safeguarding Board Safeguarding Adults Review request form

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### Details of individual/ organisation requesting the SAR:

<b>Name</b>	
<b>Position/Designation</b>	
<b>Organisation</b>	
<b>Address</b>	
<b>Contact telephone</b>	
<b>Contact email</b>	

<b>Authorising Manager</b>	
<b>Position / Designation</b>	
<b>Contact telephone</b>	
<b>Contact email</b>	

<b>Date of request</b>	
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### Details of adult at risk:

<b>Name</b>			
<b>Address</b>			
<b>Date of Birth</b>		<b>Date of Death (if applicable)</b>	
<b>Ethnicity</b>			
<b>GP (if known)</b>			
<b>Family / NoK / Advocate / representative</b>			
<b>Health and / or other presenting needs</b>			

**Details of person / organisation alleged responsible for harm**

<b>Name</b>			
<b>Address</b>			
<b>Date of Birth</b>		<b>Date of Death (if applicable)</b>	
<b>Ethnicity</b>			
<b>GP (if known)</b>			
<b>Relationship to adult at risk</b>			
<b>Health and/or other presenting needs</b>			

**Details of SAR request:**

<b>Brief outline of the case/incident (with dates and locations if known)</b>

<b>What learning do you think can be achieved through a review of this case?</b>

<b>Summary of why this case meets the criteria for a SAR (see section 2, SAR framework)</b>
<i>Please establish the link between cause of death / harm and the (suspected) abuse / neglect. Please include the views of the adult / family / carer where known.</i>

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<b>Do you believe a statutory SAR is required in response to this case?</b>	<b>Yes</b>		<b>No</b>	
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<b>Has any other learning / review process already been followed (e.g. internally)?</b>	<b>Yes</b>		<b>No</b>	
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<b>If yes, please specify the review conducted, learning identified, how it was disseminated, and impact.</b>

<b>List of individuals and their agencies/service providers known to be involved in the case.</b>
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<b>Any other relevant information that will help the SAFEGUARDING BOARD decide whether a SAR is required.</b>
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**Submit by post:**

The Business Unit  
 Bracknell Forest Safeguarding Board  
 c/o Bracknell Forest Council,

**Submit by email**

[BFSB@bracknell-forest.gov.uk](mailto:BFSB@bracknell-forest.gov.uk)

*If you do not have access to secure email, please contact*

Time Square,  
Market Street, Bracknell RG12 1JD

*the SAFEGUARDING BOARD Business Manager via the  
above email address to discuss alternative arrangements  
for submission.*

Marked: Restricted – Addressee only

To protect sensitive personal information, this form MUST only be sent by secure email, or by registered post.

## **Appendix 2b: SBA 2 Bracknell Forest Safeguarding Board Safeguarding Adults Review – request for information form**

### **Bracknell Forest Safeguarding Board Template for the consideration of a Safeguarding Adults Review (SAR)**

The Board requires this information to help establish if the criteria for a SAR is met.

<b>Start date and end date of involvement with your agency</b>
<b>A brief overview of your agency's involvement with the individual/ family</b>
<b>Comment on the quality of your agency's service</b>
<b>Did your agency have any concerns about the quality of interagency working</b>

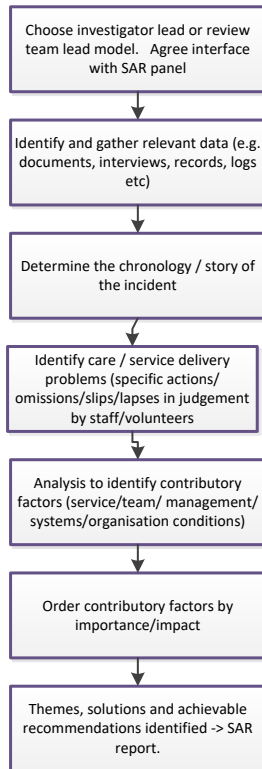




This is a selection of methodologies set out by SCIE. The Bracknell Forest Safeguarding Board will develop other methodologies using the components of these models as a toolkit.

These will be considered alongside the more traditional model of appointing a SAR Panel under an independent Chair; identifying IMR writers and producing an independent report as set out in appendix 6 based on panel discussion of the IMRs. This may be accompanied by other elements of the below methodologies.

## Option A: Systems Analysis



### Key Features:

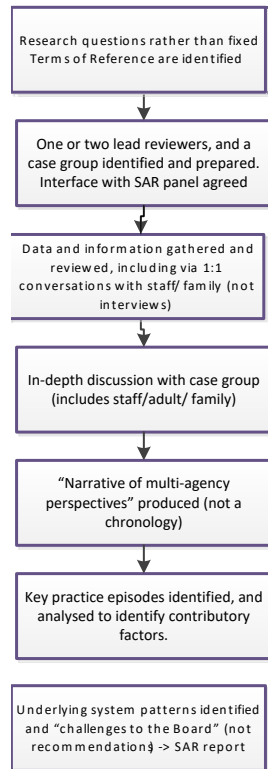
- ✓ Team/investigator led
- ✓ Staff/adult/family involved via interviews
- ✓ No single agency management reports
- ✓ Integrated Chronology
- ✓ Looks at what happened and why, and reflects on gaps in the system to identify areas for change

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Structured process of reflection</li> <li>• Reduced burden on individual agencies to produce management reports</li> <li>• Analysis from a team of reviewers may provide a more balanced view</li> <li>• Managed approach to staff involvement may fit well where criminal investigations are ongoing</li> <li>• Enables identification of multiple causes/contributory factors.</li> <li>• Range of pre-existing analysis tools <a href="#">available</a></li> <li>• Focusses on areas with greatest potential to cause future incidents</li> <li>• Based on thorough academic research and review</li> <li>• RCA tried and tested in healthcare and familiar to health sector Safeguarding Board members</li> </ul>	<ul style="list-style-type: none"> <li>• Burden of analysis falls on small team/individual, rather than each agency contributing its own analysis via a management report. May result in reduced single agency ownership of learning/actions.</li> <li>• Staff/family involvement limited to contributing data, not to analysis.</li> <li>• Potential for data inconsistency/conflict, with no formal channel for clarification</li> <li>• Unfamiliar process to most SAFEGUARDING BOARD members</li> <li>• Trained reviewers not widely available</li> <li>• Structured process may mean it is not light touch</li> <li>• RCA may be more suited to single events/incidents and not complex multi-agency issues</li> </ul>

### Available models:

- Vincent et. al. (2003) [Systems analysis of clinical incidents: the London Protocol](#)  
 Woloshynowych et. al. (2005) [Investigation and analysis of critical incidents](#)  
 NHS National Patient Safety Agency (NPSA) [Root Cause Analysis](#)

## Option B: Learning Together



### Available models:

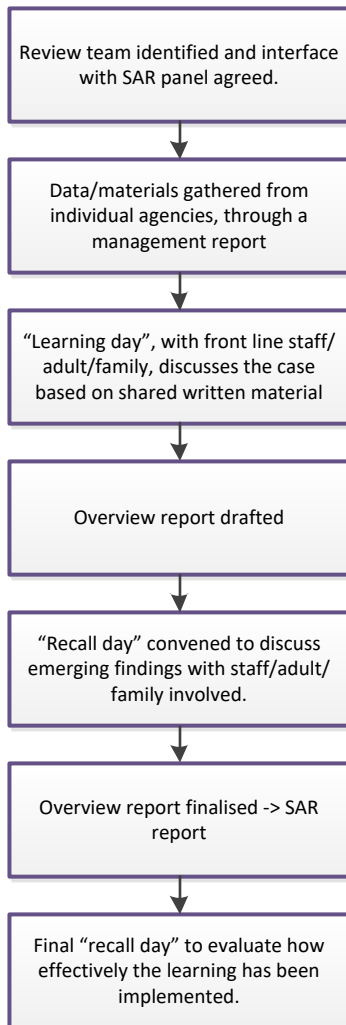
SCIE, [Learning Together](#)

### Key Features:

- ✓ Lead reviewer led, with case group
- ✓ Staff/adult/family involved via case group and 1:1 conversations
- ✓ No single agency management reports
- ✓ Integrated narrative; no chronology
- ✓ Aims to identify underlying patterns/factors that support good practice or create safe conditions.

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Structured process of reflection</li> <li>• Reduced burden on individual agencies to produce management reports</li> <li>• Analysis from a team of reviewers and case group may provide a more balanced view</li> <li>• Staff and volunteers participate fully in case group to provide information and test findings</li> <li>• Enables identification of multiple causes/contributory factors</li> <li>• Tried and tested in children’s safeguarding</li> <li>• Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity</li> <li>• Range of pre-existing analysis tools <a href="#">available</a></li> </ul>	<ul style="list-style-type: none"> <li>• Burden of analysis falls on a small team/individual, rather than each agency contributing its own analysis via a management report. May results in reduced single agency ownership of learning/actions.</li> <li>• Challenge of managing the process with large numbers of professionals/family involved.</li> <li>• Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.</li> <li>• Cost – either to train in-house reviewers, or commission SCIE reviewers for each SAR.</li> <li>• Opportunity costs or professionals spending large amounts of time in meetings?</li> <li>• Unfamiliar process to most SAFEGUARDING BOARD members.</li> <li>• Structured process may mean it is not light touch.</li> </ul>

## Option C: Significant Incident Learning Process



### Key Features:

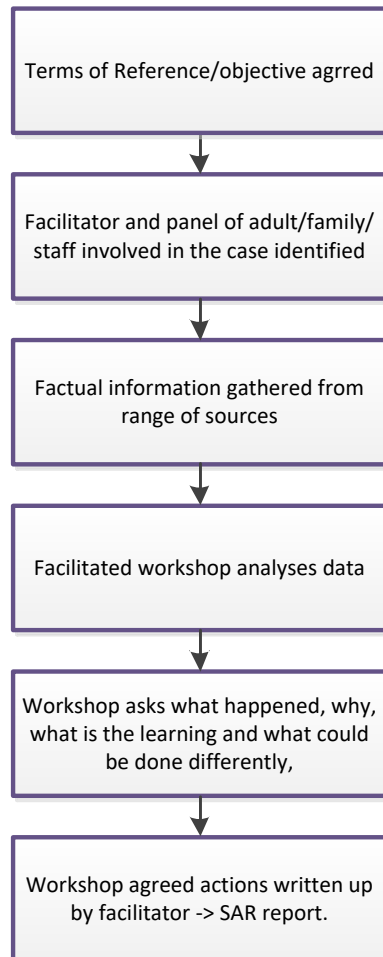
- ✓ Review team and learning day led
- ✓ Staff/family involved via learning days
- ✓ Single agency management reports
- ✓ No chronology
- ✓ Multiple learning days over time
- ✓ Explores the professionals' view at the time of events, and analyses what happened and why

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Flexible process of reflection – may offer more scope for taking a light touch approach</li> <li>• Transparently facilitates staff and family participation in a structured way: easier to manage large numbers of participants,</li> <li>• Has similarities to traditional SCR approach so more familiar to most Safeguarding Board members.</li> <li>• Agency management reports may better support single agency ownership of learning/actions</li> <li>• Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• Burden on individual agencies to produce management reports</li> <li>• Cost – either to train in-house reviewers, or commission SILP reviewers for each SAR.</li> <li>• Opportunity costs of professionals spending large amounts of time in learning days</li> <li>• Wide staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.</li> <li>• Not been widely tried or tested, nor gone through academic research/review.</li> </ul>

### Available models:

Tudor, [Significant Incident Learning Process](#)

## Option D: Significant Event Analysis



### Key Features:

- ✓ Group led (via panel), with facilitator
- ✓ Staff/adult/family involved via panel
- ✓ No chronology
- ✓ No single agency management reports

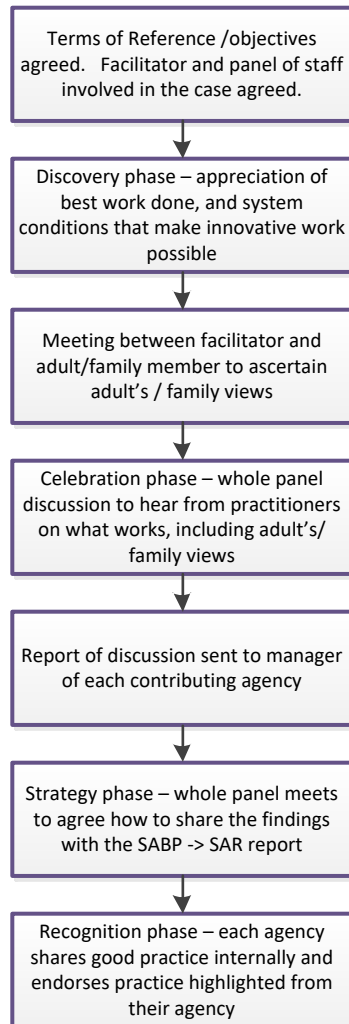
- ✓ One workshop: quick, cheap
- ✓ Aims to understand what happened and why, encourages reflection and change

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Light touch and cost-effective approach</li> <li>• Yields learning quickly</li> <li>• Full contribution of learning from staff involved in the case</li> <li>• Shared ownership of learning</li> <li>• Reduced burden on individual agencies to produce management reports</li> <li>• May suit less complex or high-profile cases</li> <li>• Trained reviewers not required</li> <li>• Familiar to health colleagues</li> </ul>	<ul style="list-style-type: none"> <li>• Not designed to cope with complex cases</li> <li>• Lack of independent review team may undermine transparency/legitimacy</li> <li>• Speed of review may reduce opportunities for consideration</li> <li>• Not designed to involve the family</li> <li>• Staff involvement may not suit cases where criminal proceedings are ongoing and staff are witnesses.</li> </ul>

### Available models:

NHS Education for Scotland and NPSA, [Significant Event Analysis](#)  
 Care Quality Commission, [Significant Event Analysis](#)  
 Royal College of General Practitioners, [Significant Event Audit](#)

## Option E: Appreciative Inquiry



### Key Features:

- ✓ Panel led, with facilitator
- ✓ Staff involved via panel. Adult/family involved via meeting
- ✓ No chronology/management reports
- ✓ Aims to find out what went right and what works in the system, and to identify changes to make so this happens more often

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Light touch, cost effective and yields learning quickly – process can be completed in 2-3 days</li> <li>• Staff who worked on the case are fully involved</li> <li>• Shared ownership of learning</li> <li>• Effective model for good practice cases</li> <li>• Some trained facilitators available</li> <li>• Well-researched and reviewed academic model</li> <li>• Model understood fairly widely</li> </ul>	<ul style="list-style-type: none"> <li>• Not designed to cope with 'poor practice'/systems failure cases</li> <li>• Adult/family only involved via meeting</li> <li>• Speed of review may reduce opportunities for consideration</li> <li>• Model not well developed or tested in safeguarding. Minimal guidance available.</li> </ul>

### Available models:

Julie Barnes, [A new model for learning from serious case reviews](#)  
 Newcastle Safeguarding Children's Board, [Appreciative Inquiry Champions Group](#)

## Appendix 4: Standard Letters

### Standard letter A – response to SAR request.

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Dear

**Re: Safeguarding Adults Review** - *name and date of birth of adult at risk, case file reference (if known)*.

Thank you for your request for the above case to be considered as a Safeguarding Adults Review (SAR).

In line with the Bracknell Forest Safeguarding Board's SAR Framework, the designated members of the Bracknell Forest Safeguarding Board met on *dd/mm/yyyy* to consider whether the criteria for a SAR have been met, and if so, what SAR methodology would be most appropriate and beneficial to use in this case.

The decision was that this case (does / does not) meet the criteria to commission a SAR for the following reasons:

- 
- 
- 
- 

It was agreed that the most appropriate SAR methodology to use for this case is *XXXXXXXXXXXXXXXXXXXX*

I will now write to the Chief Executives (or equivalent) of all relevant agencies to notify them of the case and the decision to commission a SAR.

*OR (delete as appropriate)*

If you are dissatisfied with this outcome, you can appeal the decision as outlined in [Section 9.1](#) of the Bracknell Forest Safeguarding Adults SAR Framework.

Yours sincerely,

**Bracknell Forest Safeguarding Board Manager**

On behalf of the Bracknell Forest Safeguarding Board.

## Standard letter B – Notification to relevant agencies of SAR initiation.

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**RESTRICTED** – Requires urgent attention

Dear

**Re: Safeguarding Adults Review** - name and date of birth of adult at risk, case file reference if known

A decision has been taken that the above-named adult at risk is to be made the subject of a safeguarding Adults review (SAR), using XXXXXXXXXX methodology. This will be undertaken in line with the Bracknell Forest Safeguarding Board SAR Framework

The purpose of this SAR is to establish whether there are any issues in relation to interagency working in line with the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures, whether anything could have been done differently to predict or prevent the abuse and/or neglect, and whether there are any lessons to be learned to enhance partnership working, improve outcomes for adults and families, and prevent similar abuse and/or neglect occurring in the future. To achieve this, each agency that has been involved with the family is required to look openly and critically at their professional practice with the adult at risk.

As Chair of the Bracknell Forest Safeguarding Board, I am writing formally to request that you:

- a) Take action to ensure that your agency files in respect of the above-named person are immediately secured to guard against potential loss or interference, and to enable the SAR process to commence. *(if required, insert here details of any specific records that are affected – e.g. GP notes, home visit records etc.)*

*OR (delete as applicable)*

- b) Identify a representative of sufficient seniority and experience from your organisation, and who is independent of the case in question, to sit on the SAR Panel and contribute to the review process. I would be grateful if you could forward to me the name and contact details of the appointed individual as soon as possible.

At this stage you and your organisation's nominated representative may wish to familiarise yourselves with the Bracknell Forest Safeguarding Board SAR Framework and, in particular, the methodology that has been selected for this review. Given that a traditional SAR methodology has been selected, at this stage you may also wish to start identifying a manager (or independent person) of sufficient seniority and experience to undertake your individual management review. The manager appointed should have had no line management relationship with the practitioners working with the person, nor any direct contact with them themselves. Guidance on individual management reviews will be made available at a meeting of panel members and IMR writers early in a SAR process. All organisations contributing to a SAR need to be mindful that there may be public scrutiny of the information provided to the SAR by organisations and in particular, HM Coroner may request information. All organisations are therefore advised to ensure that senior managers approve any written submissions to the SAR, and where they consider it appropriate, seek legal advice prior to submission.

Thank you for your assistance in this important matter. Please do not hesitate to contact the Safeguarding Board Business Manager or myself with any queries.

Yours sincerely

**Bracknell Forest Safeguarding Board Business Manager**

**On behalf of the Bracknell Forest Safeguarding Board**

## Appendix 5: SAR Terms of Reference & Confidentiality Statement

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### The Bracknell Forest Safeguarding Board Safeguarding Adults Review of *Code/Initials*.....

#### Terms of Reference

#### **Overarching aim and principles of the SAR**

The purpose and underpinning principles of this SAR are set out in section 2.9 of the Multi- Agency Safeguarding Adults Policy and Procedures. All Safeguarding Board members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

#### **Legislation**

Section 44 of the Care Act 2014 places a statutory requirement on Bracknell Forest Safeguarding Board to commission and learn from SARs in specific circumstances, as laid out below, and confers on the Board the power to commission a SAR into any other case:

*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 Safeguarding Board, members of it or other persons with relevant functions worked together to safeguard the adult, and*
- b) the adult had died, and the Safeguarding Board knows or suspects that the adult has experienced serious abuse or neglect., or*
- c) the adult is still alive, and the Safeguarding Board knows or suspects that the adult has experienced serious abuse or neglect.*

*Each member of the Safeguarding Board must co-operate in and contribute to the carrying out of a review under this section with a view to:-*

- a) identifying the lessons to be learnt from the adult's case, and*
- b) applying those lessons to future cases.*

#### **Governance and accountability**

This SAR will be conducted in accordance with the requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014)
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015)
- Multi-Agency Safeguarding Adults Policy and Procedures; and
- Bracknell Forest SAR protocol

As the accountable body responsible for its commissioning, Bracknell Forest Safeguarding Board will receive updates on the progress of this SAR at Board meetings, or via offline written briefings as required.



**SAR subjects (redact before publishing)**

The summary of details of the subject(s) of the SAR are:

Name	DoB	DoD	Age	Known and previous addresses
<i>Subject</i>				

Name	DoB	DoD	Age	Known and previous addresses
<i>Perpetrator(s)</i>				

**Brief summary of the concerns that triggered this SAR**

**SAR methodology**

XXXXXXXXXX has been selected as the methodology for conducting this SAR. This methodology has been selected because XXXXXXXXXXXX. Details of the methodology can be found in [Safeguarding Adults Reviews under the Care Act: implementation support](#)

**Specific areas of enquiry**

The SAR Panel (and by extension all contributors) will consider and reflect on the following:

- 1.
- 2.
- 3.
- 4.
- 5.

The SAR should cover the time period *dd/mm/yyyy* to *dd/mm/yyyy*

**Timescales for completion**

This SAR will commence on *dd/mm/yyyy* and should be complete within six months. However, this may be affected any criminal proceedings and the review may be suspended pending any court case and resumed when any trial is concluded. Everyone involved in the SAR process must be mindful of not jeopardising any criminal proceedings.

## Chair and membership of the SAR Panel

The chair and panel membership for this SAR have been determined as follows:

Name	Organisation	Secure email*
	(SAR chair)	
	(SAR report author)	
	(Support Officer)	

*\*In line with the confidentiality statement, all communication regarding this SAR that contains personal and / or sensitive information MUST be sent securely using the secure email addresses provided. Please contact the Business Manager with any queries regarding how to contact another panel member securely.*

The skills, knowledge, and experience required of the SAR chair are set out in [section 5](#) of the Bracknell Safeguarding Board SAR Framework. The independence of the chair from the case under review can be evidenced by XXXXXXXXXXXX.

The role and responsibilities of CCG and NHS England in relation to this SAR are particularly focused around enabling and facilitating engagement with health partners, and the identification and bringing together of key strategic themes and issues across the local health economy. *(Delete/ adapt as applicable).*

### Administrative and professional support

The Business Manager will coordinate panel meetings and, where possible, circulate all documents at least five working days in advance of each meeting. Minutes will be taken by an appropriate officer.

### Evidence and submissions to the SAR

It has been agreed that the following organisations are to submit evidence to the SAR:

Organisation	Nature of the evidence to be submitted	Deadline

**SAR report and publication**

XXXXXXXXXX has been appointed to author the SAR report, the content of which is to be in line with [section 9](#) of the Bracknell Forest Safeguarding Board SAR Framework and the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of full SAR Report and/or an Executive Summary will be published on XXXXXXXXXXXX unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR Panel will discuss with the Bracknell Forest Safeguarding Board how to publish the report, setting out clear reasons for the any recommendations.

Timings for publication may be affected by any criminal proceedings and court cases, and the SAR report may be held for publication until such time as the proceedings / case(s) has concluded. In the meanwhile, any lessons learned can be taken forward immediately.

**Involving and supporting the adult and family / friends / carers** *(redact before publishing)*

The review will seek to involve the adult at risk and family/ friends/ carers *(delete/ adapt as applicable)* in this SAR.

OR

The SAR chair has agreed with the adult at risk and family/ friends/ carers *(delete/ adapt as applicable)* that they would/ would not like to be involved.

Name	Connection to the adult	Nature/timing of the involvement	Support agreed

The adult at risk and their family/friends/carers *(delete/adapt as applicable)* has indicated they *would/would not (delete as applicable)* like to be kept informed of progress/conclusions.

**Involving and supporting key staff and volunteers**

The review will seek to hear the perspectives of all key staff and volunteers by *dd/mm/yyyy*.

The SAR Panel member from each agency is responsible for identifying and notifying relevant staff and volunteers of this SAR and giving them the opportunity to share their views on the case.

The SAR Panel member from each agency is responsible for ensuring relevant staff and volunteers are provided with a safe environment to discuss their feelings and offered emotional support where needed, including counseling or other therapeutic support.

**Disclosure and confidentiality**

Confidentiality should be maintained by all Safeguarding Board members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, the Berkshire Multi-Agency Adult Safeguarding Policy and Procedures, and [section 6](#) of the Bracknell Forest Safeguarding Board SAR Framework.

All Safeguarding Board member organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, the Bracknell Forest Safeguarding Board may use its powers under Section 45 of the Care Act to obtain the relevant information. The Chair of the Bracknell Forest Safeguarding Board and/or the SAR chair may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/ guidance, or meet with review participants.

Criminal proceedings may be running in parallel to this SAR, and in such cases all material received by the SAR Panel must be disclosed to the police if and as requested.

Individuals will be granted anonymity within the SAR report and will be referred to by an alias as agreed by the SAR Panel.

#### **Communications and media strategy**

Communications advice will be provided and the communications approach managed in partnership with all relevant organisations. All media queries for cases involving criminal proceedings should be referred to Thames Valley Police.

#### **Legal advice**

Legal advice will be sought by the SAR Chair as required to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

#### **Liaison with the police, criminal justice system and coroner**

There are *no/ the following* police or coroner's investigations ongoing linked to this case:

- 

The SAR Chair has agreed the following arrangements to link the review and ongoing investigations:

- 
- 
- 

The SAR Chair will be responsible for ensuring appropriate ongoing liaison with the Crown Prosecution Service, Coroner and the Police as required.

#### **Links to parallel reviews**

The SAR Panel has identified that this review links to *\*no other/ the following* other ongoing statutory reviews:

- 

The SAR Chair has agreed the following arrangements for dovetailing the reviews and reducing duplication:

- 
- 
- 

The SAR Panel shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, children's Serious Case Reviews or a SAR being conducted by another Safeguarding Board.

#### **Funding and resourcing**

It has been agreed that the funding of this SAR will be provided by

#### **Review of Terms of Reference**

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of the Bracknell Forest Safeguarding Board.

## Confidentiality Statement

The following confidentiality statement is to be read and signed by each SAR contributing agency representative and returned to the Board Manager.

### **The Bracknell Forest Safeguarding Board Safeguarding Adults Review: *Code/initials***

I, the undersigned, confirm my understanding and acceptance of the following confidentiality requirements in relation to this SAR:

- All sensitive, personal and other information and documentation will be shared in the strictest confidence. It is expected that the duty of confidence will be maintained in line with the requirements of Data Protection legislation and local protocols for the sharing of information, including Caldicott requirements within Health and Social Care.
- All information received or given (including all documentation and notes, whether in electronic or hard copy form) must be held securely and safely. All material relating to the review must be kept together in one place. This includes information stored electronically which will normally be supplied in protected form.
- Electronic data may only be stored on agency systems. Memory sticks or other portable devices must not be used for this purpose.
- All documentation should be marked 'Confidential' and may not be disclosed to others without the prior written consent of the Chair of the SAR Panel or the Chair of the Bracknell Forest Safeguarding Board.
- All information discussed at any meetings as part of this review is and remains strictly confidential. It may not be discussed, disclosed or in any other way made available to other parties without the prior written consent of the Chair of the SAR Panel or the Chair of the Bracknell Forest Safeguarding Board.
- The unauthorised disclosure of information outside of meetings, beyond that which has been agreed and recorded within the minutes as part of this review, may have legal consequences. This would be considered a breach of the subject(s)'s confidentiality and a breach of the confidentiality requirements of the agencies involved and dealt with accordingly.
- All information and documentation supplied as part of the review is the property of the Bracknell Forest Safeguarding Board. It remains the confidential property of the Board even when stored within agency systems. All materials must be returned to the Chair of the Bracknell Forest Safeguarding Board on request, at the end of meetings, or at the end of the review process.

Advice on these requirements is available from the Business Manager of the Bracknell Forest Safeguarding Board

**Signed:** .....

**Name:** .....

**Role:** .....

**Organisation:** .....

**Date:** .....

## Appendix 6: SAR report and Action Plan guidance and template

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The SAR report must be delivered within timescales and according to the agreed terms of reference. The report must collate and analyse the information and evidence presented to the SAR Panel, highlight lessons learned and make practical recommendations on areas the safeguarding partnership should address to improve joint working and outcomes for adults and their families.

The report should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible;
- Include enough of the evidence, analysis and "working out" for the SAR Panel and the Bracknell Forest Safeguarding Board to scrutinise, critique and quality assure it;
- Be written in plain English; and
- Contain findings of practical value to organisations and professionals.

Templates for a report and Safeguarding Board Action Plan are provided overleaf. As with all such reviews precise format that will be used depends on the features of the case and methodology used and will be set in the terms of reference.

All contributing agencies or individuals will have the opportunity to ensure their information is fully and fairly represented in the report before it is presented to the Chair of the SAR Panel for comment and then to the full Board for approval and action planning.

The whole report or parts of it may be made available to partners and to the CQC if appropriate. The Overview Report may include an Executive Summary which may be made public.

The SAR Panel may propose a multi-agency action plan to append to the report, for discussion by the Bracknell Forest Safeguarding Board Case Review Subgroup and which will be presented to each organisation for endorsement at senior level.

# BRACKNELL FOREST SAFEGUARDING BOARD

## SAFEGUARDING ADULTS REVIEW REPORT

Adult at risk male/ female: initials: case file reference: code

Date of birth

Date of death / age at time of incident  
*(all anonymised if appropriate)*

Report Author  
including title, qualifications and organisation *(if applicable)*

Date of Report

## **1. Introduction**

Give a summary of the aims of the report and the individual who is the subject of the review.

Clarify that the SAR has been conducted as either a statutory review under Section 44 of the Care Act, or as a non-statutory SAR as agreed by the Bracknell Forest Safeguarding Board. Set out that this SAR has been undertaken in line with the Multi-Agency Safeguarding Adults Policy and Procedures and with the Bracknell Forest Safeguarding Board's SAR Framework.

Clarify that the SAR is not intended to reinvestigate the case or apportion blame, but to learn lessons and make recommendations to improve practice, procedures and systems and ultimately improve the safeguarding and wellbeing of adults in the future.

## **2. The circumstances that led to a SAR being undertaken in this case.**

Provide a brief and anonymous overview of the specific individual circumstances that led to a SAR being undertaken for this case.

Provide reasons for conducting the review and what SAR criteria were met (or if the criteria were not met the reason for conducting the review).

Provide outline of methodology to be used.

State decision (and date this was taken) to hold the SAR.

## **3. Terms of reference**

State when the SAR commenced, details of the commissioner (the Bracknell Forest Board), SAR Chair and Panel members, and the report author.

State the dates the SAR Panel met and agreed terms of reference for the SAR.

List contributors to the review and the nature of their contributions. Cite contribution of family members/carers and any others. Include any communication with CQC or Government Offices. Set out how the involvement of staff and the adult/ family/ friends/carers was facilitated and supported (e.g. advocacy).

Identify the key issues within the SAR. Comment upon the quality of the evidence supplied and whether any action was required. Provide an explanation for any delay in completing the SAR in relation to the SAR framework and Terms of Reference.

## **4. Case summary: the facts**

Provide a brief case summary including details of the incident, kind of maltreatment, who was believed responsible for the abuse. This should include:

- A pictorial display of the adult at risk's relationship to family members, extended family and household and any care services provided. Details provided should be brief and anonymous (as appropriate).
- An integrated chronology or narrative of agency involvement with the adult at risk, family/ carer on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology/ narrative each occasion on which the adult at risk was seen and the adult at risk's views and wishes sought or expressed.
- An overview that summarises what relevant information was known to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult at risk.

## **5. Analysis**

Look at how and why events occurred, decisions made and actions taken/not taken Explain how events and conditions had looked to professionals at the time of the incident and in the period leading up to it.

Explore the range of contributory factors and systems conditions that played a part in causing the abuse or neglect.

Consider whether different decisions or actions may have led to an alternative course of events.

Consider how system conditions would have needed to be different to facilitate the different actions or decisions that would have been required.

Highlight any examples of good practice.



## **6. Conclusions and recommendations**

Summarise, in the opinion of the SAR Panel, the key themes and patterns in the system arising from the SAR and what lessons can be drawn from the case.

Translate the lessons into recommendations for areas Bracknell Forest Safeguarding Board should address to improve partnership working and outcomes for adult at risk at their families.

Recommendations should be few in number, focused and specific, and capable of being translated into an achievable action plan. Views on how the recommendations can be translated into action can be included. Consideration should be given to the resources required to implement the recommendations such as cost.

Recommendations should be divided into:

- Review - practice that should already be happening
- New - actions that need to be introduced and implemented.

If there are lessons for national, as well as local, policy and practice these should also be highlighted.

## **7. Proposed multi-agency action plan**

The author and SAR Panel will provide a proposed set of actions for discussion, adoption and approval by the Bracknell Forest Safeguarding Board. The action plans should support the implementation of the recommendations identified in section 6 of the report. The actions identified should be multi-agency in nature: requiring the combined action of a number of partners in order to achieve them. Some single agency actions may be identified where these are vital to the implementation of the recommendations. The action plan should conclude with a statement on how the plan will be reviewed to determine if the outcomes have been achieved.

An example multi-agency action plan template is provided below:

**SAR multi-agency action plan**  
**The Bracknell Forest Safeguarding Board**

	Identified action	Expected outcome	Evidence of completion	Barriers to implementation, and mitigations	Lead person / partner	Target Date	Progress
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

**Guidelines for completing SAR action plans:**

Identified actions should be focused and specific, and capable of being implemented. They can be actions that have or will be taken. Example actions may include: delivering training, developing new policies, introducing new standards, review working practices, etc.

Expected outcomes are the difference these changes will make to people in need of care and support / patients, and may include: referrals for safeguarding, quicker or better quality interventions, having to re-tell their story to fewer professionals, feeling safer etc.

Evidence of completion can be used to show the Bracknell Forest Safeguarding Board how actions are being undertaken or achieved, and may include: performance data, personal / patient feedback, minutes of meetings, new policies, training material, etc.

Barriers to implementation and mitigations is anything that may prevent/ hamper the partnership from taking the action forward, and what is being/ has been put in place to minimise the risk of the action not being progressed

Target date - provide the date action was completed and/or provide a realistic timescale for the partnership to address the identified action.

Progress column provides space for the partnership to record, monitor and report on the implementation of the actions - state whether the action is 'complete', 'in progress' or 'delayed'. If 'delayed' provide an updated target date. The partnership may use a RAG rating to monitor progress.

## Appendix 7: Acknowledgements

Bracknell Forest Safeguarding Board would like to acknowledge the use of the following sources in the development of this SAR framework:

[Camden Safeguarding Adults Partnership Board: Safeguarding Adults Review Framework 2015](#)

[Camden Safeguarding Children's Board \(2014\), Learning and Improvement Framework \(unpublished\).](#)

[Ibbetson, K. \(2014\), Alternative SCR methodologies and overview of useful literature \(unpublished paper to Camden Safeguarding Children's Board\).](#)

[ADASS \(2013\), Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services](#)

[Bestjan, S. \(2012\) Serious safeguarding adults reviews: guidance note on options for London](#)

[Bowie, P., and Pringle, M., \(2008\), Significant Event Audit: Guidance for Primary Care Teams](#)

[Department of Health \(2014\), Care and Support Statutory Guidance Issued under the Care Act 2014](#)

[Fish, S., Munro, E., and Birstow, Learning together to safeguard children: developing a multi-agency systems approach for case reviews](#)

[Fish, S., Munro, E., and Birstow, S. \(2010\), Piloting the SCIE systems model for case reviews](#)

[Gateshead Safeguarding Adults Board \(2013\) Safeguarding Adults Review Protocol](#)

[Hampshire Safeguarding Adults Board \(2014\), Multi-Agency Learning and Review Framework: Learning from Experience to Improve Practice.](#)

[Leeds Safeguarding Adults Board \(2013\), Leeds Safeguarding Board Safeguarding Adults Review Policy and Toolkit](#)

[London ADASS Improvement Team \(2015\), London Multi-Agency Safeguarding Adults Policy and Procedures \(draft\).](#)

[Munro, E., and Lushey, C. \(2013\), Undertaking SCRs using the SCIE Learning Together model - lessons from the pilots \(Childhood Wellbeing Research Centre\).](#)

[SCIE \(2015\), Safeguarding Adults Reviews under the Care Act: implementation support.](#)

[UK Parliament \(2014\), Care Act 2014.](#)

[West Midlands Region \(undated\), Safeguarding Adults Case Review Framework \(unpublished\).](#)