City of York Safeguarding Adult Board

Procedure

For

Safeguarding Adult Reviews

July 2026

review July 2027

INDEX

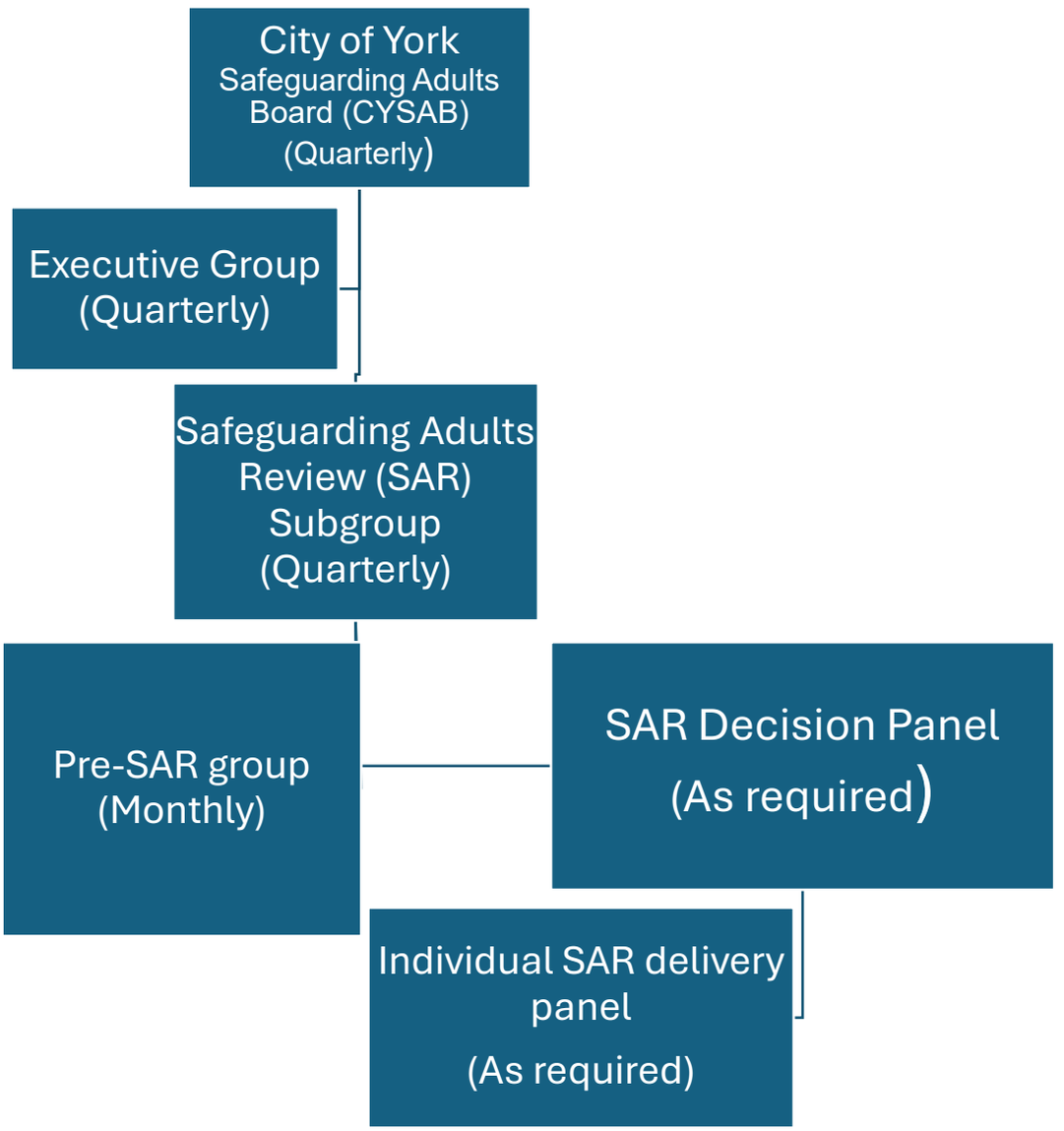
1. Introduction

1.1 The Care Act 2014 provides a statutory basis for learning and review processes. Safeguarding Adults Reviews (SARs) provide an opportunity to learn lessons when abuse or neglect is suspected to be a factor in the death or serious harm of an adult with care and support needs.

1.2 It is the responsibility of all partner agencies to make a referral for a SAR where there are reasonable grounds to consider the criteria for a SAR are likely to have been met.

1.3 All partner agencies have a responsibility to ensure that staff know the criteria for a SAR, their purpose and function. All partner agency staff must know how to refer a case for consideration via the CYSAB Business Unit.

1.4 The SAR related meeting structure can be seen below:



1.5 The quarterly SAR Subgroup maintains oversight of and monitors progress of all SARs. Underneath this, SAR referrals are received into individual SAR Decision Panels. These will consider whether the referral meets the criteria to conduct a SAR, a decision which is ultimately ratified by the CYSAB Independent Chair.

1.6 A SAR Decision Panel must include an appropriate senior representative from the following agencies:

1.6.1 City of York Council (CYC) Adult Care Services (ASC)
1.6.2 North Yorkshire Police
1.6.3 Humber and North Yorkshire Health and Care Partnership (ICB)

1.7 A SAR Decision Panel will be considered quorate with representation from the three statutory agencies (North Yorkshire Police, Local Authority and Integrated Care Board), who are required to be of appropriate seniority and experience.

1.8 Other relevant representatives that have had involvement with the case will be invited as required, to assist with decision making around S44 criteria.

1.9 The CYSAB, via its Independent Chair, is the only body in the City of York that commissions SARs.

1.10 Commissioned SARS will be actioned via individual SAR panels, with progress fed back into the SAR Subgroup.

1.11 The policy and practice undertaken by the CYSAB strives to reflect the SAR Quality Markers published by the Social Care Institute for Excellence (SCIE). A copy of the markers can be found here: https://www.scie.org.uk/safeguarding/adults/reviews/quality-markers

1.12 In addition, the Essential Guide to SARs, published in May 2026 by the National Network for Chairs of SAB's, is used locally as a reference point to navigate the SAR process. **https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews?categoryId=32#resources**

2. Purpose

2.1 The SAR is a statutory learning-focused process, designed to have practical value by illuminating barriers and enablers to good practice, untangling systemic risks, and progressing improvement activities.

2.2 The purpose of a SAR is to determine where multi-agency working went well and what might have been done differently that could contribute towards preventing similar harm or death reoccurring in the future. It therefore requires outcomes that:

2.2.1 Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies were involved in the care and support of an adult at risk of abuse and / or neglect

2.2.2 Review the effectiveness of safeguarding systems, procedures and practice both of individual organisations and multi-agency arrangements.

2.2.3 Inform and improve future practice by acting on the findings (developing best practice across all organisations)

2.2.4 Highlight any good systems, procedures, practice or opportunities to improve, identified within the review.

2.2.5 Lead to recommendations to be implemented.

2.3 The purpose of the review is not to identify or apportion blame or hold any individual or organisation to account as other processes exist for this, including coronial procedures, criminal proceedings, disciplinary procedures, employment law and professional regulation.

3. Criteria for a SAR

3.1 Under section 44 of the Care Act 2015, A 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.

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).

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.

A SAB may arrange for there to be a review of any other 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).

Each member of the SAB 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.

3.2 Where the mandatory SAR criteria is met a SAR must be commissioned. A SAR will be led by an author who will be responsible for undertaking the review, developing the recommendations and writing the report. In most cases, this will be an independent author commissioned to undertake the SAR on behalf of the CYSAB. The Independent Chair will then consider how this is done and whether a full review needs to be undertaken if the learning has already been identified but not yet actioned. e.g. learning has been taken from a similar SAR, or consideration of thematic reviews.

3.3 Where referrals relate to individuals who have died or been seriously injured within the City of York area, but it is more appropriate for another area to conduct a review or another SAB, this will be considered by the independent Chair who will discuss the matter with the appropriate board Chair. The default position in the absence of agreement will be that the SAB where the death or injury occurred will be the commissioning board.

3.4 The CYSAB may also undertake a SAR in situations where it believes that there will be value in doing so. 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 and can include exploring examples of good practice. This will be actioned at the discretion of the SAR Decision Panel and with agreement by the CYSAB chair.

3.5 Following a significant event, active consideration should be made as to whether a referral for a SAR is required. To support this, organisations should consider including an appropriate trigger question on internal incident reporting, investigation and/or review templates, or have appropriate mechanisms in place to be able to readily identify scenarios that require referring into the SAR process.

3.6 It is important to note that the SAR notification process does not affect any internal review processes.

3.7 Section 45 of the Care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with care and support needs. If the SAB requests relevant information from an organisation or person, then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB.

3.8 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 serious or significant harm as a result of the abuse or neglect

4 Making a SAR Referral

4.1 Any agency representative, local councillors, Members of Parliament or professional **MUST** refer a case believed to meet the threshold of the criteria identified above (see 3.1)in a timely manner, by completing the completing the online SAR Referral Form available on the CYSAB here https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews/make-safeguarding-adults-review-referral. Part A of the SAR referral form (Appendix A) also reflects the online form but the online version is preferred.

4.2 A case may also be referred by other interested parties including the family as above.

4.3 The SAR Decision Panel may choose to invite those making a referral in their professional role to present the case to the panel. This is to enhance the opportunity to understand fully the context of the case prior to a decision being made.

5. Making decisions on a SAR referral

Within 5 working days, on receipt of a referral, the CYSAB Business Unit will:

- acknowledge the notification,
- quality check the referral, and seek further information if required,
- advise the SAR Subgroup Chair and CYSAB Independent Chair of the referral.

5.2 Once the referral is accepted, a Safeguarding Adult Review – Scoping Form (Appendix B) will be issued to relevant partner agencies by the CYSAB Business Unit. This includes any services that have had involvement with the person. The purpose of this is to collect relevant information that adequately informs the discussion on whether the SAR criteria are met.

5.3 Accepted SAR referrals will be considered at the next monthly SAR Decision Panel meeting, providing this

is quorate. If not, then an extraordinary meeting will be arranged.

5.4 In deciding whether a SAR should be recommended, the SAR Decision Panel must first consider whether the s.44 criteria for a SAR is met using the criteria outlined in paragraph 3.1 above.

5.5 Appropriate scrutiny should be applied to the Safeguarding Adult Review Scoping Form with each agency involved presenting their information followed by respectful challenge from Partner agencies present when determining whether the statutory criteria are met.

5.6 When considering a SAR referral, the SAR Decision Panel will need to establish if there is learning from a multi-agency or single-agency perspective. It is important that consideration be given to the increasingly complex landscape of the commissioning and provision of services.

5.7 The SAR Decision Panel will break from the meeting for ten minutes for each member to submit their written rationale as to whether the SAR criteria is met or not. When the meeting resumes any difference of opinion will be explored in order to reach a consensus. The CYSAB Business Manager is not part of the decision-making process, however they will have a key role in ensuring correct process is followed. If the recommendation is that the SAR criteria is met, then consideration will also be given to the suggested methodology.

5.8 The SAR Decision Panel's recommendation as to whether the SAR criteria is met will be sent to the CYSAB Independent Chair who will make the decision as to whether to ratify the decision of whether to undertake a SAR or not. The referrer will be notified of the outcome by the Business Manager and recorded using part B of the SAR Referral Form (Appendix A)

5.9 If a unanimous recommendation is not achieved by the SAR Decision Panel then a majority decision will be shared with the CYSAB Independent Chair who will decide whether the criteria is met and whether to undertake a SAR.

5.10 The SAR Decision Panel may consider that although the mandatory s.44 criteria is not met, there will be benefit in conducting a SAR or recommending a single-agency review to promote effective learning and improvement action in order to prevent deaths or serious harm occurring in the future, under s.44(4) of the Care Act 2014. These reviews can provide useful insights into the way organisations are working together to prevent and reduce the abuse and neglect of adults in the City of York.

5.12 It is important to advise the SAR Decision Panel of any governance issues and/or if there are any other parallel proceedings, for example, police investigations, or Patient Safety Incident Response Framework.

5.13 If the person has died, the CYSAB Business Unit may contact the Coroner to identify whether an inquest has or will be held; and also advise the Coroner's Office of the intention to undertake a Safeguarding Adult Review.

5.14 The SAR Decision Panel will also consider whether the referral meets the criteria for another review or learning process e.g., Domestic Abuse Related Death Review (DARDR). This may provide an opportunity for a joint review process to be considered but does not negate the obligation for CYSAB to undertake a SAR, where criteria have been met.

5.15 SAR process will not as a matter of course share material gathered as part of the SAR with another agency or parallel proceedings without the approval of the CYSAB Independent Chair.

5.16 Should the referrer challenge the decision of the SAR Decision Panel the Independent Chair of the CYSAB will respond. The decision can be re-visited if new information has come to light. Any challenge to the decision

should be made for the attention of the CYSAB Independent Chair via the Business Unit e-mail within 28 days of the feedback being received.

5.17 The CYSAB Business Unit will support the SAR Subgroup to keep a record of all cases that: have been referred; considered for a SAR; and the outcomes of the decisions made. A summary report of cases will be provided on a quarterly basis to the Safeguarding Adults Board.

6. Undertaking a SAR

6.1 Where the s.44 criteria is met, the CYSAB Independent Chair is responsible for deciding whether a review is undertaken or not and agreeing the rationale for this. For instance, in some cases learning may already have been gathered through an alternative learning process and another review would only duplicate this learning.

6.2 Once the decision has been made to instigate a SAR, the Business Unit on behalf of the CYSAB Independent Chair will write to the nominated lead of each organisation concerned advising them that a SAR is being commissioned and requesting them to nominate an appropriate senior member of staff to support the review process. Contact will be made with the Senior Investigating Officer from the relevant police force if criminal investigation is underway, to ensure any review does not undermine police investigations. The SAR may include information already gathered through other investigations (e.g., Safeguarding Enquiries, NHS Patient Safety Incident Response Framework investigations).

6.3 An Independent Author with the requisite knowledge, skills, experience and availability will be identified to undertake the SAR. An Expression of Interest will be developed by the Business Manager and sent through formal procurement channels. The Expression of Interest will include brief details of the case, key area of focus and indicative cost. Commissioning an Independent Author will follow the formal framework as per the City of York Council procurement process.

6.4 The selection will include a declaration that the person does not hold any conflicts of interest in accepting the appointment. If any conflicts of interest arise during the process of the review the Independent Author must declare this at the earliest opportunity to the Business Manager and SAR Delivery Panel.

6.5 The Independent Author will be selected on their merits by the CYSAB Business Manager, SAR Subgroup and other relevant senior professionals. Information pertaining to the SAR will be shared with the Independent Author securely.

6.6. The CYSAB Business Manager will convene a SAR Delivery Panel to meet at the earliest opportunity. The SAR Delivery Panel will comprise of relevant senior representatives from the key organisations involved in the case. A Chair will also be appointed to lead the SAR Delivery Panel; in most cases this will be the commissioned Independent Author of the SAR.

6.7 The relevant SAR Delivery Panel will be responsible for progressing the SAR process from commissioning through to action planning. (see section 15.8 to 15.10 in the Essential Guide to Safeguarding Adults Reviews (SAR) for more information about the role of the SAR Delivery panel) **https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews?categoryId=32#resources**

6.8 The methodology selected by the SAR Delivery Panel must offer the most effective involvement of key staff/family balanced with the anticipated length of time required to conduct the review and the proposed financial commitment in order to gain the most effective learning. (Appendix C) details the types of methodologies available, these are suggested types, and a hybrid approach may be used (see section 7, Making a decision on SAR methodology).

6.9 The SAR Delivery Panel will agree the Terms of Reference which will outline the most proportionate and appropriate methodology and avoid the potential for duplication of learning elsewhere. The Terms of Reference should follow the principle of Making Safeguarding Personal, and the six Adult Safeguarding Principles as set out in the Care Act 2014 and CYSAB's Multi-6.9

6.10 The Terms of Reference should include an appropriate pseudonym unless otherwise agreed by the Chair. Consideration will be given to asking family members (or the person themselves if they are involved in the process) regarding the appropriateness of the pseudonym.

6.11 The SAR Delivery Panel and the Independent Author once identified, should consider and record who will and will not be consulted as part of the review and the rationale for doing so.

6.12 If the subject of the review is alive, the SAR Delivery Panel will give consideration to a communication plan within the Terms of Reference. This will outline who is responsible for liaising with the person and/or their representative, and which relevant legal requirements will need to be followed.

6.13 Where there is agreed involvement of the person and/or their family, then in discussion with them, the SAR Delivery Panel and the Independent Author, will agree how they will be involved during the preparation of the report and in the final written report.

6.14 The SAR Delivery Panel will nominate and agree an individual within the SAB partnership to communicate with the family whilst the SAR is being undertaken and information for families (Appendix D) Where the person and/or their family do not wish to be involved in the development of the report this will be respected. However. they will still be offered an opportunity to review the draft report via a method as agreed with them with support if required. More information about involvement of families is in section 11 of the Essential Guide to Safeguarding Adults Reviews (SAR) https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews?categoryId=32#resources

6.15 Via the CYSAB Business Unit, the CYSAB Independent Chair will write to the family or significant others in cases where the subject is no longer alive to inform them of the SAR, explain the process and purpose, and inform them of their point of contact. This should be completed as soon as practically possible. Reasonable and appropriate support and adjustments should be made by CYSAB as required to enable the adult(s), their family and/or representatives to participate in the SAR.

6.16 Once the Independent Author has been contracted, the timescales for completing the SAR will commence. Every effort will be made to complete the review within six months from which the Independent Author is appointed. Where this will be not be possible, the matter will be discussed at the SAR Subgroup meeting and with the CYSAB Independent Chair. Updates will be recorded in the minutes of the SAR Delivery Panel and SAR Subgroup meetings. Interested parties, such as the family will be notified as felt appropriate.

6.17 The SAR Delivery Panel will monitor progress of the SAR and discuss whether any amendments to the Terms of Reference are required.

6.18 Nominated agency representatives are required under the Care Act 2014 to supply all information that may be relevant to the SAR within the identified time parameters. They must ensure that they coordinate with other relevant members of their organisation to obtain the fullest understanding of their interactions. Partner agencies will be sent a Letter to notify them of the SAR decision and likely involvement. Appendix B.

6.19 Nominated agency representatives also have a responsibility to explain the SAR process to others in their organisation and provide reassurance and support to their colleagues throughout the process. This support should be clearly identified and communicated to all staff involved. The death or serious injury of an adult at risk will have an impact on staff and consideration will need to be given as to who is appropriate to represent the case and how that person is supported by their organisation.

6.20 The SAR Subgroup will receive and agree the draft report before it is presented to CYSAB, so that individually and collectively partners are satisfied that the panel's analysis and recommendations have been fully and fairly represented.

6.21 Family or identified representatives (or adult(s), if alive) should be given the opportunity to see the SAR report and recommendations. Ordinarily, two weeks will be afforded to read the SAR and provide any response. However, extensions will be granted at the discretion of the SAR Subgroup Chair if deemed appropriate to do so.

7. Making a decision on SAR methodology

Once it has been agreed to commission a SAR, the SAR Delivery Panel will decide on the most appropriate and proportionate methodology to use. The Essential Guide to Safeguarding Adults Reviews (SARs) Chapter 16 – provides comprehensive information on SAR Methodologies https://nationalnetwork.org.uk/Approved%20Essential%20Guide%20to%20Safeguarding%20Adult%20Reviews%20(SARs).pdf

Whichever SAR methodology is employed, the following key elements should be included:

SAR Delivery Panel – scrutinises information submitted to the review. The panel size should be proportionate to the nature and complexity of the review but should comprise a minimum of three members in addition to an appropriate chair, independent from who made the referral, and any other relevant agencies.

SAR Delivery Panel Chair – should be independent from who made the referral, and with appropriate skills, knowledge and experience. This may be the Independent Author.

Terms of Reference – compiled by the SAR Delivery Panel and published as part of the review. These may be amended in consultation with the Independent Author as the review progresses.

Early discussions with the adult if alive and if appropriate, their family, carers and representative – to agree on if and how they will be involved and how frequently they will be updated. Where appropriate, advocacy can be offered. See Appendix E which is available here https://www.safeguardingadultsyork.org.uk/downloads/file/18/sar-information-for-families-and-carers

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

SAR report and recommendations – should provide a sound analysis of what happened, why and what action needs to be taken to prevent reoccurrence, if possible; be written in plain English; and contain findings of practical value to organisations and professionals.

The following should be considered in selecting a SAR methodology:

8. Outcomes and Impact from SARs

8.1 The SAR report should:
Highlight key episodes, providing insight into good practice and opportunities to improve practice, systemic risks and multi-agency working. Recommendations should demonstrate where practice needs to improve and should:
– Identify the need for change to prevent re-occurrence.
– Be written with a view to being published.
– Be sensitive to the case details and level of information included as judged necessary to illustrate learning, whilst respecting the wishes of the individual or their family.

8.2 The SAR Delivery Panel has a responsibility to ensure there has been sufficient analysis, scrutiny and evaluation of evidence throughout the process. Recommendations must be of practical value, evidencing the wider outcome focused learning identified about routine barriers and enablers to good practice, systemic risks and/or what has facilitated or obstructed change to date.

8.3 The CYSAB Business Unit 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 in line with CYSAB's information sharing agreement, the General Data Protection Regulation (GDPR) and any other legal requirements.

8.4 Once completed the SAR report will be added to the agenda for the next CYSAB meeting. CYSAB are responsible for final sign off of the SAR report and for agreeing a timetable for publication. Where possible the Independent Author will be asked to present the report with findings and recommendations for the approval of SAB members. An extraordinary SAB meeting may be arranged to receive the report if waiting for the planned SAB meeting would add a delay to the report being published.

8.5 The true value of a SAR is only realised when the learning leads to demonstrable improvements in safeguarding practice, culture, and outcomes for adults with care and support needs. In addition to completion of the associated SAR action plan, partner organisations will be asked for evidence of

impact that the published SARs have had in their respective organisations for inclusion in the SAB Annual Report.

9. Implementation of actions from SARs

9.1 The CYSAB is responsible for ensuring any learning identified within the report has clear recommendations to action change. The SAR Delivery Panel will develop an action plan to deliver on the recommendations which must be SMART (Specific, Measurable, Achievable, Relevant and Time bound, identifying an owner for each action.

9.2 The SAR subgroup will be responsible for monitoring the action plan to completion. CYSAB members will be held accountable for these actions at board meetings and via the SAR Delivery Panel and SAR Subgroup.

9.3 Action plans will be monitored by the SAR Subgroup who will meet a minimum of four times a year to review and check progress on each action. Quarterly feedback will be fed into the CYSAB through quarterly reporting.

9.4 When all actions are completed, the SAR Subgroup will recommend the action plan for closure in the quarterly report to the SAB . It is the responsibility of CYSAB members to ensure that learning and service change from any safeguarding review is understood, embedded and evidenced with their organisation, to ensure impact is measured. More information on measuring impact can be found in Improving and Measuring the Impact from Safeguarding Adults Reviews - A toolkit to support sector-led improvement which can be accessed https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews?categoryId=32#resources

9.5 Further assurance will be sought by the SAR Subgroup 12 months thereafter to ensure changes in practice have been embedded and the impact can be evidenced.

9.6 Regular reports on the overall work of SAR Subgroup including 'live' referrals, action plans, including any themes and reviews will be presented to the CYSAB by the SAR Subgroup Chair.

9.7 A summary of the impact of SARs will be published in the CYSAB annual report which will be available on the CYSAB website

10 Communicating outcome of SARs

10.1 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. More information can be found in section 24 of the Essential Guide to Safeguarding Adults Reviews (SAR).

10.2 Media and communication activity about the SAR will be co-ordinated by the City of York Council's Communications and Media Department on behalf of the Board liaising with partners communication teams as appropriate.

10.3 The CYSAB must include the findings from any SAR in its annual report and include what actions it has taken, or intends to take, in relation to those findings. Where the CYSAB is unable to implement a recommendation then it must state the reason for that decision in the annual report. The CYSAB maintains a public record, actions and commentary to enable public accountability.

10.4 CYSAB will ensure that SAR publications will be submitted for inclusion in the national SAR library link https://nationalnetwork.org.uk/

10.5 Where the recommendations for a SAR are linked to national issues and government policy, these will be escalated to the National SAB Chairs Network via the CYSAB Independent Chair. Any actions accepted by the national group will be updated on individual SAR action plans and agreed as completed locally pending any further instruction.

10.6 It should be noted that SARs sit outside of any CYSAB partner retention policy.

11.Dispute resolution - Managing Disagreement and Escalation

11.1 Disagreement during a SAR, whether about scope, methodology, findings, or recommendation 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 Subgroup. The Chair for the SAR Subgroup plays a pivotal role in ensuring all voices are heard and that differing views are explored respectfully.

11.2 If consensus cannot be reached, the SAR Delivery 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.

11.3 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 SAR Delivery panel members, including statutory partners or key stakeholders. These situations should be handled with professionalism, openness, and a commitment to safeguarding learning.

11.4 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. The CYSAB Independent Chair must ensure that the review remains independent, evidence-informed, and aligned with the statutory purpose of promoting learning and improving safeguarding practice. The CYSAB Independent 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.

11.5 The CYSAB retains ultimate responsibility for the SAR process. Where a dispute arises, it shall be dealt with as follows:

a) Those responsible for the relevant part of the SAR process shall attempt to resolve the dispute, for example, the SAR Subgroup and/or the SAR Delivery Panel and the CYSAB Executive Group during the review. Any concern that cannot be resolved will be escalated to the CYSAB Independent Chair for a final decision.

b) For disputes relating to the report content, the objecting party will provide written representation setting out their concerns to the SAR Subgroup within five working days of being advised that the final draft report will not be amended.

c) Where the CYSAB Independent Chair is unable to resolve the dispute, they may recommend that a reference to the dispute, and why it was not possible to resolve, should be included as an addendum to the report. This will be shared with the SAB

d) Throughout the SAR process the following areas will be encouraged at all stages

- open dialogue among SAR participants, including practitioners, families, and reviewers will be encouraged
- Setting expectations that challenge is welcomed as part of learning, not blame.
- Use of facilitated reflective sessions to surface differing views safely
- Use of mediation or peer review if consensus cannot be reached on key findings

Appendix A Referral form for a Safeguarding Adult Review

NB: The preferred way of making a SAR referral is using the online form which is on the CYSAB website below

https://www.safeguardingadultsyork.org.uk/safeguarding-adult-reviews/make-safeguarding-adults-review-referral

City of York Safeguarding Adults Board
Safeguarding Adults Review (SAR) Referral form
PART A – Case details
(Referring agency to complete Part A and return to SAB@york.gov.uk email)

The Care Act guidance states the following in regard to SARs. The following link provides more details.
https://www.legislation.gov.uk/ukpga/2014/23/section/44
Safeguarding Adult Reviews (SARs)

- 14.162 SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- 14.163 SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.
- 14.164 The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

1. Referrer Details

Name		**Job Role**	
Agency			
Address			
Tel No		**Email**	
Date of referral:			
Please confirm if this referral has been signed off by your agency safeguarding lead:	**Yes** ☐	**Name of Safeguarding Lead** *Please insert below:*	
	No ☐		

2. Details of the adult

Name:	
Address:	
Date of Birth:	
Date of Death *(where applicable)*:	
Ethnicity:	
Gender	
Name and address of GP:	

3. Consent/ Mental Capacity of the adult

Is the adult alive?	***Yes*** ☐ ***No*** ☐
If YES, *please confirm if the adult has been informed of this referral. If not, please provide brief details of why the adult has not been informed below?* *Please note it is expected that the adult will always be informed, exceptional circumstances should be discussed with the agency Safeguarding lead.*	
In your professional opinion, does the subject have capacity to take part in the SAR process?	***Yes*** ☐ ***No*** ☐

4. Details of family/ advocate and/or significant others

Name of family/ advocate and/or significant others	Relationship to adult	Has the adult's family/ advocate and/or significant others been informed of this referral?
		Yes ☐ **No** ☐ **Not known** ☐
		Yes ☐ **No** ☐ **Not known** ☐
		Yes ☐ **No** ☐ **Not known** ☐
		Yes ☐ **No** ☐ **Not known** ☐

5. Please indicate why, in your opinion the case should be considered for a Safeguarding Adults Review (SAR)

Please provide a brief description the circumstances of this case. A full chronology is **not** required for screening purposes. *For example, details of allegation of abuse or neglect, agency responses, key decisions made, any safeguarding procedures (500 Max)*
When a case is referred for a SAR the following questions should be answered to determine if the case meets the statutory criteria for a SAR.
Does the adult have care and support needs? *Please provide details below*
Did the adult die or suffer significant harm? *Please provide details below*
Is there a suspicion that abuse, or neglect contributed to the death or significant harm? *Please provide details below*
Is there a reasonable cause for concern about how agencies worked together to safeguard the adult or evidence that one or more of the agencies involved did not support joint agency working? *Please provide details below*
Does the case provide an opportunity to learn from good practice that could be applied to agencies working with adults? *Please provide details below*

6. Other Agencies you know to be involved with the adult

Agency	Contact Details: Address, Telephone and E-mail	Reason for involvement (include whether current or not)
Are any other reviews taking place regarding the case?	**Yes ☐ No ☐**	***If yes, please state name of review***

7. Coroner involvement

8. Additional information

Is the case known to the coroner?	**Yes ☐ No ☐ Not known ☐**
Has the coroner been notified of the SAR consideration?	**Yes ☐ No ☐ Not known ☐**

Please provide details of any additional information being submitted with this referral form *for example Safeguarding concern forms; S42 Enquiries; NHS Serious Incident (SI) report; Complaints investigation; Police or GP records, Photographs/body map; Coroners report; Agency Chronology or other relevant information*.

Once Part A of this referral is completed and signed off by your agency Safeguarding Lead
Please email to: SAB@york.gov.uk

PART B – SAR Decision Panel consideration and decision

Date of notification to SAB Business Manager:	
Date scoping request sent out to partners:	
Date considered by SAR Decision Panel:	
Agencies Present	
Information Reviewed	
Summary of Discussion	
Recommendation Have the criteria for a SAR been met?	
What further actions/type of SAR should take place *(if known at this point)*.	

If the SAR criteria has not been met, what alternative action is recommended?	

Name (SAR Decision Panel Chair)	
Date	
Signature	

PART C – SAB Independent Chair Review

I endorse the recommendation for a SAR to be undertaken	
I endorse the recommendation for a SAR not to be undertaken	
Further information/ clarification is required (refer to SAR Decision Panel)	
Comments	

Name (SAB Chair)	
Date	
Signature	

Appendix B - Letter notifying partner agencies of SAR Decision

City of York Safeguarding Adults Board | West Offices | Station Rise | York YO1 6GA

Dear

Re: Name: DOB/DOD: Address:

I am writing to inform you that the City of York Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health, housing, social care and community support received by xx prior to her/his death.

Safeguarding Adult Reviews are undertaken when an adult with care and support needs dies or is seriously harmed, and abuse or neglect is suspected and there are lessons to be learned about the way agencies have worked together to prevent similar deaths or injuries in the future.

A Safeguarding Adult Review looks at how local agencies and organisations have worked together to provide services and is completely separate to any investigation being undertaken by the police or Coroner.

If your agency has had involvement with xx, you are likely to be required to be involved in the Safeguarding Adult Review. Your agency may be required to submit documentation and nominate a representative to sit on the Safeguarding Adult Review (SAR) Delivery Panel. This will all be explained once we have the information.

I look forward to hearing from you shortly to enable the SAR Delivery Panel to be set up.

Yours sincerely

On behalf of

|Independent Chair of the City of York Safeguarding Adults Board

Sent by

|Safeguarding Adults Board Business Manager

Appendix C CYSAB SAR scoping form

City of York Safeguarding Adults Board SAR Decision Panel

Scoping request form for agency information

The Care Act 2014 places a duty on Safeguarding Adult Boards (SAB) to undertake a Safeguarding Adults Review where an adult with care and support needs has died as a result of or has experienced serious abuse or neglect. [1]

This form supports the scoping of cases where it is identified that an adult with care and support needs has died as a result of, or has experienced serious abuse and neglect, and there is potential for learning by the SAB, its members and wider agencies about the way they work together to identify and respond to concerns of abuse or neglect.

Please review your agency records to identify if the named person is known to your agency and complete and return this scoping request form to sab@york.gov.uk

For CYSAB use

Adult's Name		Adult's NHS number	
Adult's Date of Birth		Date of Incident/Death	
Address including postcode		Dates Information required from and to	
Date case to be considered at SAR Decision Panel			
Cause of Death (if applicable)			
Brief overview of circumstances			

For completion by organisation

Name of Agency	

[1] Section 44 of the Care Act 2014 provides the lawful basis for sharing information and Section 45 in relation to the supply of information. Further details are available here:
http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

Care and support statutory guidance sections 14.180.186 also covers information sharing. Further details are available here:
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-14.180[1]

Name of person submitting the information	
Job Role	
Please provide brief details of your agency's involvement with the adult by considering the following questions:	
Are you aware of any other parallel reviews or processes, either complete or ongoing, in relation to this adult?	
When did your agency become aware of the adult?	
For what reason was your agency involved with the adult?	
Who was the lead worker from your agency (if known)?	
Are you aware of any other agencies involved?	
Are you aware of any family members, advocates or representatives involved with the adult?	
Was there an end date to your agency's involvement?	
If the adult is between 18 and 24 years indicate if the adult was a care leaver? *(i.e. a young person aged 16 to 25 who has been in the care of a local authority for at least 13 weeks since the age of 14, and who was still in care on or after their 16th birthday, can include foster care, children's home, private arrangements)* https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident	
Any other information that may be relevant?	
Please consider any initial observations/ early learning from information gathered.	
Please highlight any opportunities for learning for your agency, and any good practice you have identified?	
Please identify any areas for concern as to the way in which partners have worked together to safeguard the adult?	

Do the circumstances highlight any recurrent themes in the safeguarding and promotion of the welfare of adults?	

This case will be discussed at the SAR Decision Panel meeting where you will need to be fully briefed regarding information pertaining to this case to assist the SAR Decision Panel in reaching a decision regarding a potential safeguarding adults review of this case.

Once completed please return this scoping request form to sab@york.gov.uk

by ../../….

Appendix D Safeguarding Adult Review (SAR) Methodology Toolkit

Safeguarding Adult Review (SAR)Methodology Toolkit

This toolkit outlines a range of methodologies to consider and adopt for the commissioning and delivery of Safeguarding Adult Reviews (SARs).

Statutory guidance (14.164) states;

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring.

Where a referral for SAR has been agreed as meeting the criteria (Care Act 2015 s 44), the SAR sub-group will select the appropriate methodology which is proportionate for the case under review however the following should also be considered;

- Complexities of the case for review; including the proposed scope period under review.
- Parallel reviews e.g. DARDR/LeDeR; including criminal investigations as this will impact on the review.
- Ensure a proportionate approach is taken which identifies learning in a timely manner, taking into account SAB work priorities already established, or planned including SARs in progress.
- Learning from single agency reviews.
- Family engagement in the process; early engagement with family is essential.
- Appropriate involvement from professionals or organisations involved with the adult.
- Learning from previous SARs with similar themes (locally and nationally) which can inform the terms of reference and methodology.
- Aim for completion within a reasonable period of time or 6 months from initiating; commissioning completed, methodology agreed and review process commenced.

A hybrid of methodologies can be considered to provide a lens for learning which supports the terms of reference and is proportionate to the review. It is essential that the selected methodology is the 'best fit' for the circumstances and case for review. Essentially the unique circumstances of the review including the scope period should inform the selected and proportionate methodology.

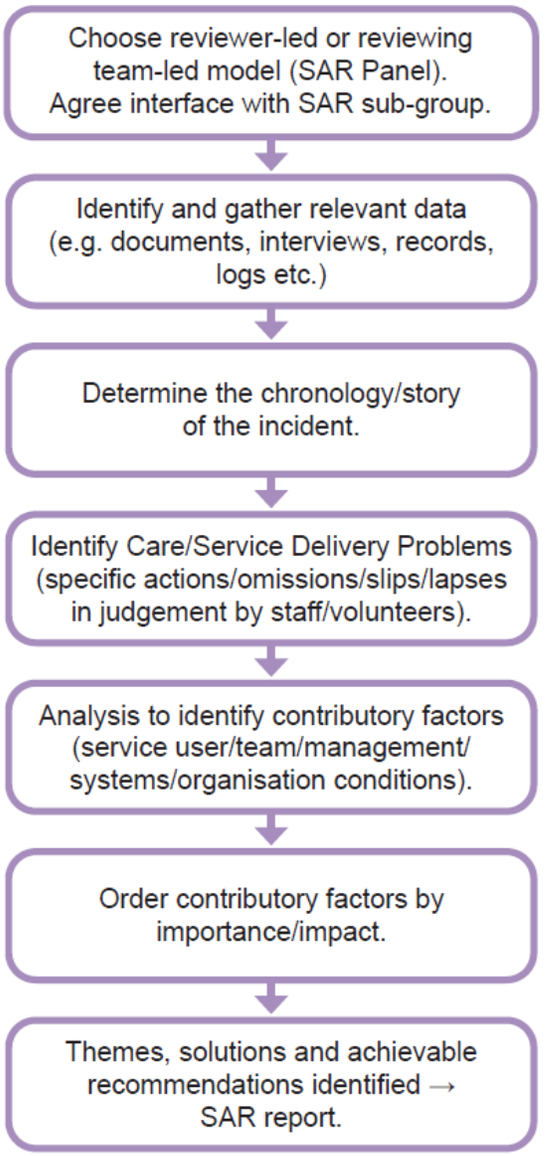
The methodologies in this toolkit can be considered when commissioning a mandatory (s44.1) or discretionary SAR (s 44.4). The toolkit can also be used where the SAB has agreed to do an informal non statutory learning review and inform the process and methodology as best practice.

Note; following ministerial guidance published in 2024, SAR referrals involving adults who are/were homeless should be considered by the SAB but are not mandatory to progress.

Social Care Institute for Excellence (SCIE) has key best practice for conducting Safeguarding Adult Reviews which should be considered when commissioning and conducting SARs. **List of 15 Safeguarding Adult Reviews Quality Markers - SCIE**

This toolkit is adapted from a model used by Kirklees SAB, thanks and acknowledgment.
cumbriasab.org.uk @cumbriasab

Option A: Systems Analysis



Key features:

- Reviewer led and/or Panel.
- 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:

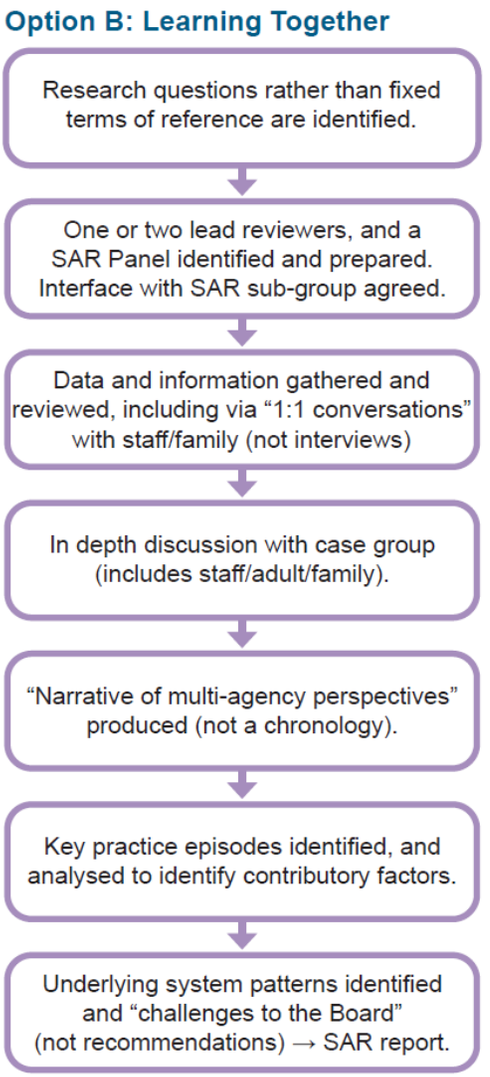
• Structured process of reflection
• Reduced burden on individual agencies to produce management reports
• Analysis from a team of reviewers may provide more balanced view
• Managed approach to staff involvement may fit well where criminal proceedings are ongoing
• Enables identification of multiple causes/ contributory factors and multiple causes
• Range of pre-existing analysis tools available (SCIE)
• Focusses on areas with greatest potential to cause future incidents
• Based on thorough academic research and review
• Root Cause Analysis* tried and tested in healthcare and familiar to health sector SAB members.

Disadvantages:

• 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.
• Staff/family involvement limited to contributing data, not to analysis.
• Potential for data inconsistency/ conflict, with no formal channel for clarification.
• Unfamiliar process to most SAB members.
• Trained reviewers not widely available
• Structured process may mean it's not light-touch.
• RCA* may be more suited to single events/incidents and not complex multi-agency issues.

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**



Key features:

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

Advantages:

- Structured process of reflection.
- Reduced burden on individual agencies to produce management reports.
- Analysis from a team of reviewers and case group may provide more balanced view.
- Staff and volunteers participate fully in case group to provide information and test findings.
- Enables identification of multiple causes/contributory factors and multiple causes.
- Tried and tested in children's safeguarding.
- Pool of accredited independent reviewers available, and opportunity to train in-house reviewers to build capacity.
- Range of pre-existing analysis tools.

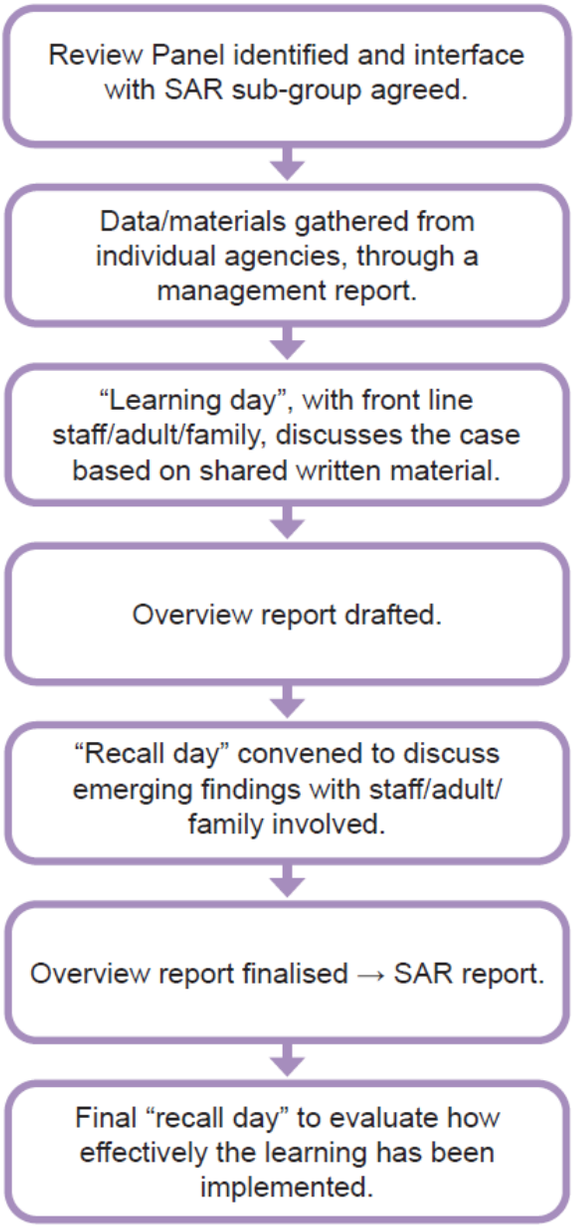
Disadvantages:

- 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.
- Challenge of managing the process with large numbers of professionals/ family involved.
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.
- Cost - either to train in-house reviewers, or commission SCIE reviewers for each SAR.
- Opportunity costs of professionals spending large amounts of time in meetings.
- Unfamiliar process to most SAB members.
- Structured process may mean it is not light-touch.

Available models:

SCIE, Learning Together

Option C: Significant Incident



Key features:

- Review Panel and learning day led.
- Staff/family involved via learning day/s.
- 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:

- Flexible process of reflection - may offer more scope for taking a light-touch approach.
- Transparently facilitates staff and family participation in structured way: easier to manage large numbers of participants.
- Has similarities to traditional SCR approach, so more familiar to most SAB members.
- Agency management reports may better support single agency ownership of learning/actions.
- Trained SILP reviewers available and opportunity to train in-house reviewers to build capacity.

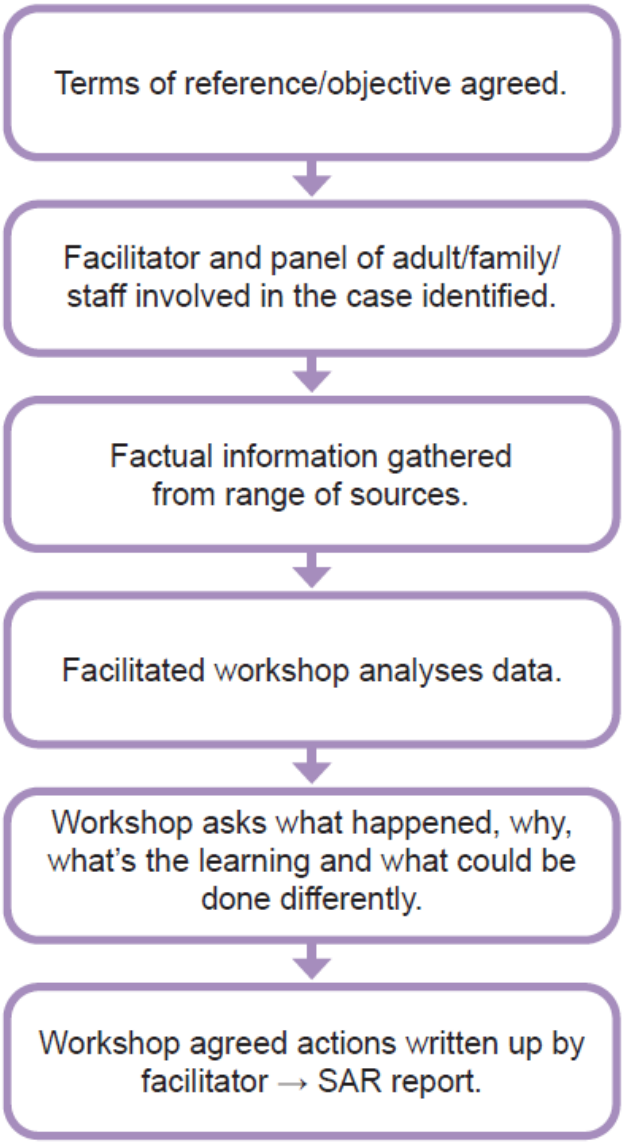
Disadvantages:

- Burden on individual agencies to produce management reports.
- Cost - either to train in-house reviewers, or commission SILP reviewers for each SAR.
- Opportunity costs of professionals spending large amounts of time in learning days.
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.
- Not been widely tried or tested, nor gone through thorough academic research/ review.

Available models:

Significant Incident Learning Process

Option D: Significant Event Analysis (Day review)



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, encourage reflection and change.

Advantages:

- Light-touch and cost-effective approach.
- Yields learning quickly.
- Full contribution of learning from staff involved in the case.
- Shared ownership of learning.
- Reduced burden on individual agencies to produce management reports.
- May suit less complex or high-profile cases.
- Trained reviewers not required.
- Familiar to health colleagues.

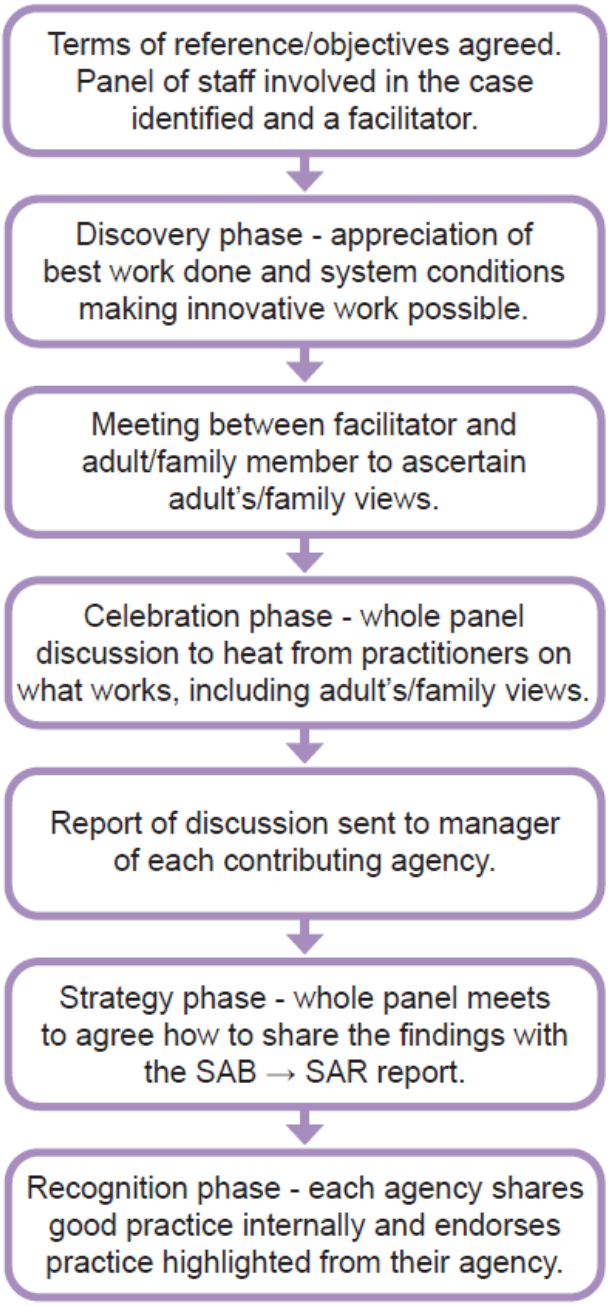
Disadvantages:

- Not designed to cope with complex cases.
- Lack of independent review team may undermine transparency/legitimacy.
- Speed of review may reduce opportunities for consideration.
- Not designed to involve the family.
- Staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.

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 identify changes to make so this happens more often.

Advantages:

• Light-touch, cost-effective and yields learning quickly - process can be completed in 2-3 days.

• Staff who worked on the case are fully involved.

• Shared ownership of learning.

• Effective model for good practice cases.

• Some trained facilitators available.

• Well-researched and reviewed academic model.

• Model understood fairly widely.

Disadvantages:

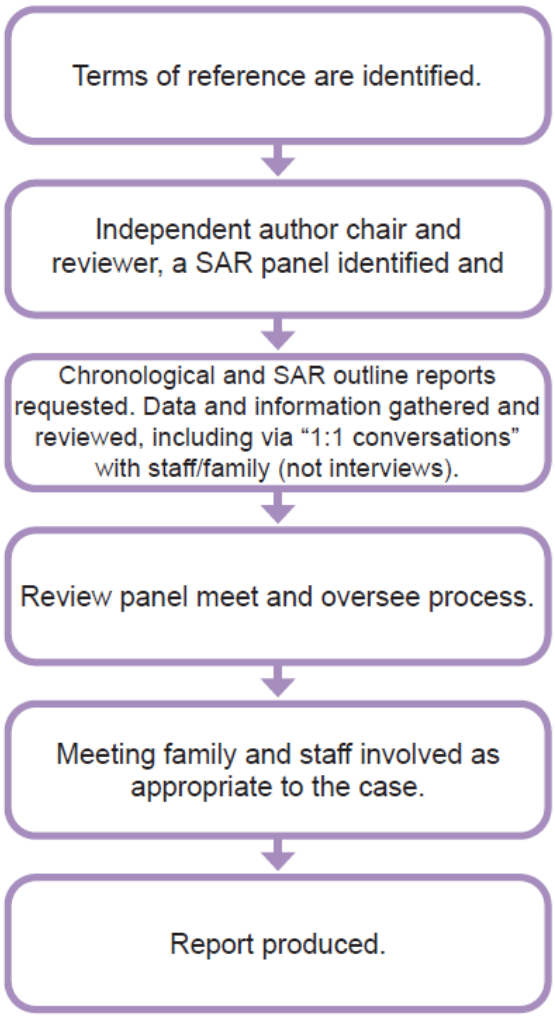
• Not designed to cope with 'poor' practice/systems 'failure' cases.

• Adult/family only involved via a meeting.

• Speed of review may reduce opportunities for consideration.

• Model not well developed or tested in safeguarding. Minimal guidance available.

Option F: Safeguarding Adults Review: Traditional Methodology



Key features:

- Panel-led with independent author/chair.
- Staff/adult/family involved via case group and 1:1 conversations.
- Single agency management reports.
- Single agency, no chronologies, then considered.
- Aims to identify underlying patterns/ factors that support good practice or create unsafe conditions.

Advantages:

- Structured process of reflection.
- Analysis from a panel and may provide more balanced view.
- Managers participate in SAR Panel.
- Practitioners participate in learning event to provide information and test findings.
- Enables identification of multiple causes/ contributory factors and multiple causes.
- Familiar process to most SAB members and wider partners.
- Range of pre-existing analysis tools available.
- Applicable if the case also meets the criteria for a Domestic Homicide Review.

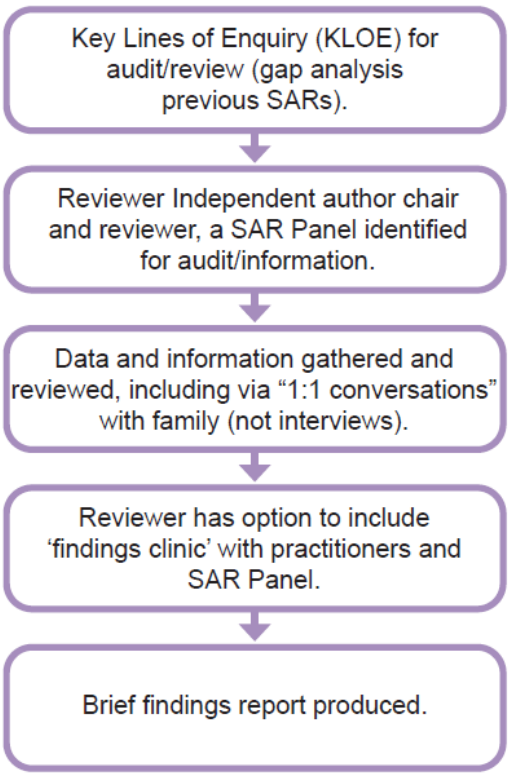
This approach can be used when conducting thematic reviews.

Disadvantages:

- Burden on individual agencies to produce management reports.
- Challenge of managing the process with large numbers of professionals/family involved.
- Wide staff involvement may not suit cases where criminal proceedings are ongoing, and staff are witnesses.
- Cost - either to train in-house reviewers, or commission SCIE reviewers for each SAR.
- Opportunity costs of professionals spending large amounts of time in meetings.
- Structured process means it is not light-touch.

Available models: SCIE Learning Together

Option G: Measurement of change analysis - desk-top review/case audit



Key features:

- Reviewer led (independent or internal).
- Can be used to test out previous SAR learning; explore unique factors. Managers/case group conduct single agency audit; opportunity to meet as group reflect Opportunity to include practitioners.
- Family involved via 1:1 conversations.
- Single agency audit, no chronologies or IMRs - information through KLOE questions.
- Aims to identify unique factors and learning to case drawing on previous learning identified.
- Reduces repeating previous SAR learning.
- Assurance and update regarding embedding previous learning.

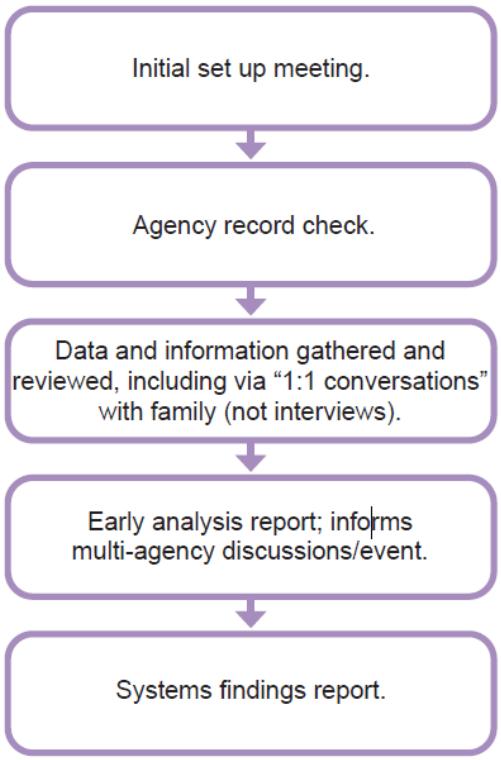
Advantages:

- Structured KLOE to inform review/audit and specific questions.
- Opportunity to include 'findings clinic' with case auditors and practitioners for reflections and more balanced view.
- Enables identification of unique factors and learning.
- Proportionate approach; reduced duplication opportunity to 'test' previous learning embedded.
- Flexibility of approaches ensures proportionate; can include 'findings
- clinic' with practitioners.
- Cost effective.
- Identify learning in a timely way.

Disadvantages:

- Requires review of previous SAR learning; inform gap analysis with case.
- Need to ensure effective engagement and contributions from family considered and inform report.
- SAB members not familiar with approach.

Option H: SAR in Rapid Time



Disadvantages:

- Commitment required to complete in rapid time.
- SAB members not familiar with approach.
- Due to time pressures; potential impact on family engagement during the review window.

Key features:

- Reviewer led (independent or internal).
- Rapid review process.
- SCIE templates and guidance.
- Nationally trained reviewers in methodology.
- Standardised processes and templates support this speedy turnaround.
- SCIE can independently facilitate the approach, or the templates and tools can be used by anyone who would like to use the model.

Advantages:

- Aims to identify learning in rapid time (SCIE model.
- Could be adapted to lengthen the 'rapid time' period.
- Trained reviewers in the methodology.
- Toolkit and templates available.
- Cost effective.
- Questions for SAB consideration; systems approach.

Appendix E - Safeguarding Adults Review – Information for families and carers

Safeguarding Adults Review

Information for families and carers

Introduction

When an adult who needs care and support either dies or suffers serious harm, and when abuse or neglect is thought to have been a factor, City of York Safeguarding Adults Board (CYSAB) may need to review what has happened. This is called a Safeguarding Adults Review or SAR for short.

Sometimes CYSAB will also arrange for a SAR to take place in other situations where they feel there might be learning for services.

These reviews are to see whether any lessons can be learned about the way organisations worked together to support and protect the person who suffered harm. The people carrying out the review understand this is likely to be a very difficult time for families, friends and carers, but they want to learn as much as possible about how to do things better in the future.

The CYSAB wants families and carers to be involved in the process as much as possible. They believe families, carers and where appropriate, the person who suffered harm should have the opportunity to discuss any concerns they may have and to share their thoughts and opinions.

This leaflet tells you what happens when a SAR is required to be undertaken, what you should expect and the support the CYSAB offers.

What is a Safeguarding Adults Review (SAR)?

The purpose of a SAR is to find out how organisations, agencies, carers and professionals can work better together in the future to keep adults at risk safe from abuse or neglect.

It is completely separate from any criminal investigation by the Police and/or the coroner, and it concentrates on the work of the professionals, organisations and agencies who have been involved with the adult to look to see if they can learn anything from what has happened.

A SAR is not an enquiry into the cause of an individual death or injury. It does not look for someone to blame.The CYSAB has a sub-group of professionals from different agencies who look at all requests for a review; this group then decides on whether a SAR needs to take place. If a review is required, this group also decide how a review is to take place. This must then be approved by the Independent Chair of the CYSAB.

How do we carry out a Safeguarding Adults Review (SAR)?

There are different ways in which a SAR can be done. Each SAR will involve gathering information from many sources. An independent person who has no involvement in the case will be asked to lead on the review and report back to the SAR sub-group. The SAR sub-group and the person leading the review will decide on what type of review will support effective learning and improvements to prevent future death or serious harm. The SAR sub-group will try to ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult.

They will also decide the best way to involve the adult and/or their family. In some cases, it may be helpful to communicate with the person who caused the abuse or neglect.

How do we involve you?

An important part of undertaking a SAR is to ask you, the family, for your view. A person nominated by the CYSAB (usually the person leading the review) can arrange to meet with you to discuss the process and make sure you are kept up to date. A suitable date, time and venue will be arranged for this.

Having support during this meeting is encouraged, this could be another family member or a family friend, an advocate or any other professional you think appropriate. Home visits will be agreed if you wish or alternatively a venue of your choice will be considered.

Sometimes a SAR can take several months to complete, but the nominated person will update you regularly and explain the reasons for any delays.

What happens after the review?

The independent person will be asked to provide the SAR sub-group with any learning and any improvement that may be required. The final report will be approved by the CYSAB.

CYSAB and the SAR sub-group will monitor the improvement plan over a period of time. The nominated person will talk to you about the outcome of the SAR and any lessons that have been learned.

There may be a report that is published on the CYSAB website; however, no individuals are named in it and no information is included that could lead to individuals involved being identified.

The CYSAB must publish an annual report which will include the findings of any SAR and subsequent improvement/s. These again will not contain any names.

If you have any questions about this process, please email the CYSAB Business Manager SAB@york.gov.uk