

“*To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities”*

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| --- | --- | --- | --- |
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**Safeguarding Adult Review Policy**

|  |  |
| --- | --- |
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| **Author / Lead:** | Levi Sinden – TSAB Manager |
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1. **Introduction**
   1. Section 44 of the Care Act 2014 specifies that Safeguarding Adults Boards (SABs) have a duty to arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as result of suspected abuse or neglect.
   2. Reviews must be conducted in line with Section 44 of the Act, however the type of review must be considered in light of individual circumstances and proportionality.
   3. Specifically, paragraph 14.162 -164 of the Care Act guidance sets out the following:
   * 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]](#footnote-1)
   1. This purpose of this document is to set out how the Thurrock Safeguarding Adults Board (TSAB) will meet its statutory obligations and how individuals and organisations can request a SAR.
   2. This policy should be considered in conjunction with the Southend, Essex and Thurrock Safeguarding Adults Policy and Procedure.
2. **Safeguarding Adult Review criteria**
   1. The purpose of any review is to explore how agencies worked together to determine whether an alternative course of action would have prevented the death or serious harm.
   2. The review will not explore which organisation or individual is responsible. Existing criminal and regulatory processes exist for this purpose, and where relevant additional investigations will commence before or alongside the SAR.
   3. The Act specifies at section 44 that a SAR **must** be conducted in circumstances where the TSAB has concerns about how members of TSAB or other agencies with relevant functions, have worked together to protect an adult in Thurrock, with care and support needs, who:
3. has died as a result of suspected abuse or neglect, or
4. is still alive, but has experienced serious abuse or neglect, and would have died if it were not for intervention, or has suffered permanent harm, reduced capacity or quality of life.
   1. In line with best practice set out in [The rough sleeping strategy](https://www.gov.uk/government/publications/the-rough-sleeping-strategy), TSAB will consider all cases for a SAR involving deaths of adults that are rough sleeping, who
      1. has died as a result of suspected abuse or neglect, or
      2. is still alive but has experienced serious abuse or neglect
   2. The Care Act guidance, paragraph 14.163 provides advice regarding the circumstances in which TSAB must conduct a SAR for an adult who is still alive.
   3. SARs that meet the above criteria will be called statutory reviews in this policy.
   4. The adult does not have to have been in receipt of care and support services under the Act, in order for the case to be considered for a SAR.
   5. The adult does not have to have been the subject of an enquiry made under Section 42 of the Act, in order for the case to be considered for a SAR.
   6. The SAR panel will consider whether the SAR will provide a learning opportunity that would assist in preventing deaths and serious harm in the future.
   7. An 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).[[2]](#footnote-2) TSAB will consider reviews for non-statutory cases where:

* there is an opportunity to explore good practice that would enhance multi-agency working;
* there are concerns that the policy or practice of one or more agencies may have hindered other agencies’ ability to protect the adult, such as information sharing or resources;
* there is concern that an emerging theme may lead to serious harm or death of an adult in Thurrock if not tackled, such as under reporting of particular types of abuse or lack of advocacy.

1. **Establishing a Safeguarding Adult Review**

* 1. Any of the following can make an application for a review:
* Any organisation that has worked with the adult
* Any organisation represented on the TSAB
* The adult concerned, their family, advocate, carer or friend, or
* Any other individual acting on the adult’s behalf such as a Coroner, MP or elected member
  1. All applications must be submitted on form SAR1, which can be found at [www.thurrocksab.org.uk](http://www.thurrocksab.org.uk) and at appendix 1 and sent to [safeguardingadults@thurrock.gov.uk](mailto:safeguardingadults@thurrock.gov.uk) .
  2. The applicant should consider the criteria set out in section 2 prior to submitting the referral.
  3. There may be a criminal investigation underway, a coroner’s inquest scheduled or other statutory investigation that has commenced such as a Domestic Homicide Review or Serious Incident investigation; this should not stop a referral being made. However, other investigations will be taken into account when considering scope and timescales of the SAR.

1. **Decision making**
   1. Only the TSAB has the authority to commission a SAR.
   2. All applications will be received by the TSAB Manager who will inform the Chair of the TSAB and convene a meeting of the SAR sub-group.
   3. The SAR sub-group will meet to consider the application giving consideration to the criteria set out at Section 44 of the Care Act. The SAR sub-group will make a recommendation to the Chair of the TSAB to:

* Conduct a statutory SAR
* Conduct a non-statutory review, or
* Decline the request

4.4 In the event that a statutory SAR is commissioned, the Chair will notify the following people:

* The person that requested the SAR
* The adult concerned or their family or advocate
* The Chief Executive of Thurrock Borough Council
* The members of the TSAB
* The relevant regulatory body
* NHS England, and
* The Care Quality Commission
  1. In the event that the decision is taken to establish a SAR, the TSAB will send notification in writing to the adult or the adult’s family and make a formal record of the reasons if the decision is taken not to contact the family.
  2. In the event that an application for a SAR is turned down, the decision will be recorded in writing and shared with the applicant and the TSAB.
  3. The final decision as to whether to proceed with a statutory or non-statutory review lies with the Chair of TSAB.

1. **Appeals**
   1. In the event that an application for a SAR is turned down, the applicant can appeal the decision by contacting the TSAB Manager.
   2. The appeal will be considered within ten working days by Assistant Director of Adult Social Care and Community Services, Chief Nurse and Super Intendant.
   3. In the event that a SAR or other type of review is commissioned, the process listed under the heading ‘Decision Making’ will commence.
2. **SAR Group**
   1. The SAR Group is a part of the TSAB governance structure and will only be convened when a SAR application is received and while a SAR is underway.
   2. Membership of the SAR Group will be:

* TSAB Manager
* Deputy Chief Nurse – Thurrock Clinical Commissioning Group
* District Commander – Essex Police
* Principal Social Worker – Thurrock Borough Council
* Voluntary sector representative
  1. Membership will be finalised on an individual basis to ensure impartiality.
  2. Panel members can be co-opted by the Chair of the SAR sub-group in order to obtain expertise in a particular area.
  3. Panel members should be independent of line management duties of any staff implicated in the case.
  4. The initial meeting of the SAR Group will discuss the application and decide whether to proceed to a review or decline the application.
  5. The Chair of the SAR Group will be responsible for providing updates to the TSAB and ensuring that the report is delivered and published within agreed timescales and expected quality.
  6. The SAR Group will agree the content of the report, summary and action plan.
  7. The SAR Group will make a recommendation to the TSAB with regard to the publication of the SAR report, and ensure that is appropriately anonymised.
  8. The SAR Group will nominate a representative to liaise with the family.
  9. This list is not exhaustive. Please refer to the SAR Group Terms of Reference for a comprehensive list of duties and governance arrangements at Appendix 2.
  10. Statutory SARs will be conducted by an individual that is independent of any organisations whose actions are subject to the review.
  11. Non – statutory reviews may be conducted by a person that is associated with the TSAB, but not directly employed by any of the organisations subject to the review.
  12. Lead reviewers/Chairs of statutory and non-statutory reviews must have the 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 ad ability to manage qualitative data
* Safeguarding knowledge
* Inclined to promote an open, reflective learning culture[[3]](#footnote-3)
  1. The TSAB will be responsible for assuring the action plan that supports the findings of the report. Assurance will include obtaining evidence that action has been taken to make service improvements, learning has been embedded and that lessons have been shared across the relevant organisations in Thurrock.

1. **Conducting the Safeguarding Adult Review**
   1. Section 45[[4]](#footnote-4) of the Act gives TSAB the authority to request information that is relevant to the investigation. Providing the request is made for the purpose of assisting the investigation and the organisation has the ability to provide the required information, they must comply with the request.
   2. The cost of the SAR will be met by the SAR fund that is held by the following Trusts as part of an agreement made with the TSAB.

* Basildon and Thurrock University Hospital NHS Foundation Trust, and
* Essex Partnership University NHS Foundation Trust
* North East London NHS Foundation Trust
  1. **Involving the adult or their family or representative**
     1. Section 14.54 of the Care Act states that an advocate must be appointed to represent and support an adult who has ‘substantial difficulty’ in being involved in a Safeguarding Adult Review, where there is no suitable alternative person to provide this support.
     2. Thurrock Borough Council is responsible for securing an advocate and meeting the cost.
     3. The representative with responsibility to liaise with the family will maintain contact with the adult or family throughout the investigation. They will share the SAR report with the family, and agree a publication date where relevant, taking into account any sensitivities such as date of death.
     4. The consent of the adult or their family or representative is not required in order for the SAR to take place.
  2. **Involving staff**
     1. Staff that have worked directly with the adult involved should be notified by their employing organisation that a SAR will be undertaken on a case that they were involved in.
     2. The lead reviewer should contact the organisation to seek involvement of their staff member in the review.
     3. Staff should be offered support in line with their organisation’s HR policies.
  3. **Allegations of misconduct**
     1. The SAR is not intended to apportion blame or manage allegations against staff. If an issue of this nature arises, the member of staff will be managed under the employing organisation’s HR processes, and in line with the Local Area Designated Officer (LADO) policy.
  4. **Timescales**
     1. The lead reviewer will be responsible for ensuring completion of the SAR and sharing the report within the recommended six months from the date that the SAR commences. If the lead reviewer believes that this is not possible, due to potential prejudice regarding related criminal proceedings, an alternative timescale should be agreed with the Chair of the SAR sub-group.
     2. The SAR Group will monitor compliance with the agreed timescales.
  5. **Methodology**
     1. Irrespective of the methodology chosen, all reviews should apply the following principles:
* There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
* The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
* Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
* Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
* Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively[[5]](#footnote-5).

1. **Conducting a SAR alongside other reviews**
   1. This policy acknowledges the interfaces with other organisations, particularly those with a statutory responsibility to investigate specific types of incidents which may involve the delivery of healthcare and therefore can coincide with serious incident investigations led by the health service. In doing so, it recognises that a variety of investigation methodologies may be applied and promotes the ever increasing need to work collaboratively in an effort to draw lessons to inform systematic learning and improvement. Ideally, only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties.
   2. The other statutory investigation framework is Serious Incident (SI) in health: <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf>
   3. The Learning Disability Mortality Review programme (LeDeR programme) has been implemented to review the deaths of people with a learning disability. Whilst this type of review is not statutory, key learning will be gleaned from such investigations and should be taken into consideration if one is running alongside a SAR.
   4. The lead reviewer/Chair will be responsible for making contact with the Chair of any other review in order to avoid duplication, explore the feasibility of jointly commissioning certain aspects of the review and aligning the reviews where practical.
   5. Where relevant the lead reviewer should seek advice from the police or Crown Prosecution Service (CPS) to ensure that the review will not prejudice criminal proceedings. The police or CPS will be responsible for advising whether the review should be postponed until the criminal case is concluded.
2. **Sharing Information**
   1. Section 45 of the Care Act places a legal duty on organisations to comply with requests for information that are received from Safeguarding Adults Boards that assist with reviews.
   2. Organisations are still required to give due consideration to the Data Protection Act 1998, but this should not be used as a reason to withhold information.
3. **Learning from Safeguarding Adult Reviews**
   1. The SAR report is considered final when signed off by the Chair of the TSAB.
   2. The TSAB Manager will ensure that the SAR report will be presented to the TSAB as soon as is practical after sign off. If this does not fit in with the existing meeting schedule, the Chair of TSAB may call an extraordinary meeting of the TSAB.
   3. The Performance, Policy and Audit Group has responsibility for assuring that actions identified within the report are completed, and will seek evidence to demonstrate that learning has been embedded within the organisation.
   4. The TSAB will escalate issues of non-compliance regarding the actions to the relevant organisation.
   5. Where appropriate the SAR report will be published on the TSAB website to allow other SABs to learn from our experience.
   6. The SAR will only be closed when the TSAB is satisfied that all actions from the SAR action plan has been completed and embedded into practice.
4. **Accountability**
   1. Terms of reference will be agreed for each review, approved by the Chair of the TSAB and be made available to the public on the TSAB website.
   2. TSAB will include findings from any SAR undertaken within its annual report, along with progress in implementing the recommendations. If TSAB decides not to implement one or more of the recommendations, an explanation will be given.
   3. TSAB will give consideration to publishing the report of each review on a case by case basis. Consideration will be given to the public interest, legal advice and confidentiality. This may mean that some sections of the report are redacted.

**Appendix 1**

“*To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities”*

**Safeguarding Adult Review Request Form**

Complete this form if you believe that an adult at risk has died or would have died if it were not for intervention, as a result of abuse or neglect.

For further information please see the Safeguarding Adult Review policy or contact the Safeguarding Adults Board Manager at [TSAB@thurrock.gov.uk](mailto:TSAB@thurrock.gov.uk) or 01375 659713.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Details of the Adult** | | | | | | |
| **First name** |  | | | | | |
| **Preferred name** |  | | | | | |
| **Surname** |  | | | | | |
| **Address** |  | | | | | |
| **Date of Birth** |  | | | | | |
| **Date of Death (if applicable)** |  | | | | | |
| **Ethnicity** |  | | | | | |
| **Religion** |  | | | | | |
| **GP Name** |  | | | | | |
| **GP Practice and Address** |  | | | | | |
| **Was the adult subject to a DoLS?** | Yes | No | **Was the adult detained under the Mental Health Act?** | | Yes | No |
|  |  | | **If yes, which section?** | |  | |
| 1. **Your details** | | | | | | |
| **Your name** |  | | | | | |
| **Your role** |  | | | | | |
| **Your relationship to the adult** |  | | | | | |
| **Organisation name** |  | | | | | |
| **Organisation address** |  | | | | | |
| **Your telephone number** | Landline | | | Mobile | | |
| **Your email address** |  | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Case summary** | | | | | |
| **Date of incident(s)** |  | | | | |
| **Location of incident(s)** |  | | | | |
| Please include type of abuse e.g. physical abuse, sexual abuse, domestic violence, psychological abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse, neglects and acts of omission, self-neglect. | | | | | |
| **Has a safeguarding concern been raised regarding the adult?** | | | Yes | No | |
| **Has another review been commissioned, such as a Domestic Homicide Review, Serious Incident or SCR?** | | | Yes | No | Unsure |
| **Are criminal proceedings underway?** | | | Yes | No | |
| **Has the adult been the subject of a S42 enquiry** | | | Yes | No | |
| 1. **Please explain how this case meets the criteria for a statutory SAR** | | | | | |
| **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** | | | Yes | No | |
| **The adult has died, and there is a suspicion that the death resulted from abuse or neglect** | | | Yes | No | |
| **The adult is still alive, and there is suspicion that the adult has experienced serious abuse or neglect** | | | Yes | No | |
| 1. **Please explain how this case meets the criteria for a non-statutory SAR** | | | | | |
| **The case provides an opportunity to learn from good practice that could be applied to agencies working with adults.** | | (please provide an explanation) | | | |
| **Whilst there are no concerns about the multi-agency working to protect the adult, there is evidence that one or more of the agencies involved did not support this joint working** | | (please provide an explanation) | | | |
| 1. **Agencies known to be involved with the adult** | | | | | |
| **Police** | |  | | | |
| **Adult Social Care** | |  | | | |
| **Basildon and Thurrock University Hospital NHS Foundation Trust** | |  | | | |
| **GP** (please provide name and address) | |  | | | |
| **Residential care home/supported living/nursing home** (please specify) | |  | | | |
| **Domiciliary care agency** (please specify) | |  | | | |
| **Community Care** (please specify e.g. District Nurse) | |  | | | |
| **MARAC/MAPPA** | |  | | | |
| **Children’s Services** | |  | | | |
| **Drug and Alcohol service** | |  | | | |
| **Mental health service** | |  | | | |
| **Housing provider** (please specify) | |  | | | |
| **Other** (please specify) | |  | | | |
|  | |  | | | |

**Please send this form to** [**TSAB@thurrock.gov.uk**](mailto:TSAB@thurrock.gov.uk)

**Appendix 2**

“*To work in partnership, preventing abuse and ensuring excellent practice and timely responses to the safety and protection of individuals or groups within our communities”*

**Terms of Reference**

|  |  |
| --- | --- |
| **Thurrock Safeguarding Adults Board**  **SAFEGUARDING ADULT REVIEW GROUP** | |
| Frequency Of Meetings: | To be determined by the needs of the SAR |
| Committee Chair: | Director Adults, Housing & Health or Head of Adult Social Care |
| Membership: | TSAB Manager  Deputy Chief Nurse – Thurrock Clinical Commissioning Group  District Commander – Essex Police  Principal Social Worker – Thurrock Borough Council  Voluntary sector representative  Membership will be finalised on an individual basis to ensure impartiality. |
| Observers and Further Representation: | The Chair may invite others with specialist knowledge/expertise dependent upon the case. |
| Secretary: | TSAB Administrator and Manager |
| Quorum: | When two Executive Members and the SAR sub-group Chair are present. |
|  |  |
| Approval: | TSAB |
| Date Approved: | 13/11/2017 |
| Version | V1.0 |
| Review Date: | Annually |

**Purpose**

The Safeguarding Adult Review (SAR) sub-group will commission, oversee, and quality assure SARs and non-statutory reviews.

**Objectives**

* To review SAR applications and decide whether it is apposite for a SAR or non-statutory review.
* The Chair of the SAR sub-group will be responsible for providing updates to the TSAB and ensuring that the report is delivered and published within agreed timescales.
* To agree the content of the report, summary and action plan.
* The make recommendations to the TSAB with regard to the publication of the SAR report, and ensure that it is appropriately anonymised.
* To ensure the SAR/non statutory review has appropriate resources.
* To create the SAR Terms of Reference.
* To recruit a lead reviewer or SAR Chair.
* To monitor the progress of the SAR.
* To ensure the Thurrock Safeguarding Adults Board is kept abreast of developments/risks.
* To liaise with the Chair(s) of other related reviews (such as DHR or SI).

**Frequency**

The SAR sub-group will be convened only when a SAR application is received and will continue to meet based upon the needs of the review, until the SAR is closed.

**Chair**

The Chair will usually be the Assistant Director of Adults, Housing & Health, Thurrock Borough Council unless it is felt that there is a conflict of interest due to the nature of the SAR. In this event the Chair will be the Chief Nurse, Thurrock CCG.

**Membership**

Members may nominate a deputy, providing they have sufficient seniority and subject knowledge to make decisions on behalf of their organisation.

**Accountability**

Meetings of the Leadership SAR sub-group will be recorded as minutes. The SAR sub-group minutes will be saved with the TOR for each SAR, supporting documentation and will be password protected.

**Appendix 3 Form: SAR2**

**Case reference:**

**Safeguarding Adult Review**

**Partner agency information request**

Thurrock Safeguarding Adult Board (TSAB) has received a Safeguarding Adult Review (SAR) application in which your organisation is cited as having provided services or had contact with the adult involved. In order to decide whether the SAR should proceed, the TSAB SAR sub-group requires the information that you hold about the adult, interactions with their support network and other agencies.

The Act specifies at section 44 that a SAR **must** be conducted in circumstances where the TSAB has concerns about how members of TSAB or other agencies with relevant functions have worked together to protect an adult in Thurrock, with care and support needs, in the following circumstances:

1. There is reasonable cause for concern about how the Safeguarding Adults Board (SAB), members of it, or other organisations worked together to safeguard the person, **And**
2. The person has died and the Safeguarding Adults Board 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). **Or**
3. The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect.

The Care Act guidance, paragraph 14.163 provides advice regarding the circumstances in which TSAB must conduct a SAR for an adult who is still alive.

An 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).[[6]](#footnote-6) TSAB will consider reviews for non-statutory cases where:

* there is an opportunity to explore good practice that would enhance multi-agency working;
* there are concerns that the policy or practice of one or more agencies may have hindered other agencies’ ability to protect the adult, such as information sharing or resources;
* there is concern that an emerging theme may lead to serious harm or death of an adult in Thurrock if not tackled, such as under reporting of particular types of abuse or lack of advocacy.

Section 45[[7]](#footnote-7) of the Act gives TSAB the authority to request information that is relevant to the investigation.

Please complete this form to set out your agency’s involvement with the adult named on this document and your work with other agencies in supporting this adult. The TSAB may request more information if this proceeds to a SAR (statutory or non-statutory).

**Case reference:**

|  |  |  |
| --- | --- | --- |
| **Details of the Adult** | | |
| **First name** |  | |
| **Preferred name** |  | |
| **Surname** |  | |
| **Address** |  | |
| **Date of Birth** |  | |
| **Ethnicity** |  | |
| **Religion** |  | |
| **Your details** | | |
| **Your name** |  | |
| **Your role** |  | |
| **Organisation name** |  | |
| **Organisation address** |  | |
| **Your telephone number** |  | |
| **Your email address** |  | |
| **Your organisation’s chronology** | | |
| **Date** | **Event/Reason** | |
|  |  | |
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|  |  | |
|  |  | |
|  |  | |
| **Case Overview** | | |
|  | | |
| **Signed:** | | **Date:** |

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1. DH 2014, Care Act statutory guidance paragraphs 14.162-164 [↑](#footnote-ref-1)
2. Care Act 2014, Section 44 [↑](#footnote-ref-2)
3. DH 2014, Care Act statutory guidance paragraphs 14.172 [↑](#footnote-ref-3)
4. Care Act 2014, Section 45 [↑](#footnote-ref-4)
5. DH 2014, Care Act statutory guidance paragraphs 14.167 [↑](#footnote-ref-5)
6. Care Act 2014, Section 44 [↑](#footnote-ref-6)
7. Care Act 2014, Section 45 [↑](#footnote-ref-7)