



Safeguarding Adult Review Notification Form

STRICTLY CONFIDENTIAL

The purpose of a Safeguarding Adult Review (SAR) is to determine what the relevant agencies and individuals involved in a case might have done differently that could have prevented harm or death. This is so that lessons can be learned and those lessons applied to future cases to prevent similar harm occurring again.

The Care Act 2014 sets out the criteria for a SAR as follows:

- a) *There is reasonable cause for concern about how the TSAB, its members or organisations worked together to safeguard the adult*

and

- b) *The adult died and the TSAB knows/suspects this was as a result of abuse or neglect*

or

- c) *The adult is still alive but the TSAB knows or suspects the adult has experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development*

The information included on this form is **confidential** and will only be shared in accordance with the Teeswide Safeguarding Adults Board Information Sharing Protocol and in the best interests of the adult/adult's family.

SECTION 1: ABOUT THE ADULT PLEASE COMPLETE IN FULL

Full Name	Mrs A	DOB	01.01.1931	Gender	Female
Address	Care Home, Billingham			Post Code	TS00
Date of Serious Incident	31.08.18	Date of Death (if applicable)	31.08.18		
Cause of Death (if applicable)					
Does/did the Adult have care and support needs? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
Main type of abuse/neglect identified:				Neglect	
Other types of abuse/neglect identified (please tick as appropriate):					
Discriminatory	Domestic Violence	Financial	Modern Slavery	Neglect	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Organisational	Physical	Self-Neglect	Psychological	Sexual	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION 2: ADULT'S REPRESENTATIVE (Details of who should be contacted if a SAR is agreed)

Full Name	Mr A	Gender	Male
Relationship to Adult	Husband		
Address	1 The Street, Billingham	Post Code	TS00
Telephone Number	01642 000000		

Once completed, please send securely to tsab.businessunit@stockton.gov.uk

SECTION 3: ABOUT THE PERSON COMPLETING THE FORM YOUR DETAILS			
Full Name	John Smith	Job Title	Service Manager
Organisation	Stockton Council	Relationship to Adult	None
Email	jsmith@council.gov.uk	Telephone Number	01642 100100

SECTION 4: OTHER AGENCIES INVOLVED* LIST AND PROVIDE CONTACT DETAILS It is important to complete this section of the form IN FULL as this will be used to contact the organisations involved for further information.				
Full Name	Address	Tel. Number	Email	Relationship to Adult
A B	Council Office	01642	AB@council.gov.uk	Social Work Team Manager
C D	Care Home	01642	CD@carehome.co.uk	Care Home Manager
E F	GP Surgery	01642	EF@gp.net.uk	GP
G H	Police HQ	01642	GH@police.uk	Investigating Officer
I J	Hospital Trust	01642	IJ@hospital.net.uk	Ward Sister
K L	Falls Service Base	01642	KL@fallservice.net.uk	Falls Assessor

*please add more rows if necessary

SECTION 5: DETAILS OF THE CASE
(This should include a clear factual outline of the concerns being raised with details of times, dates, people and places whenever possible. This will enable the SAR Sub-Group to make an informed decision on whether this meets the criteria for a Safeguarding Adult Review)
<p>Mrs A had lived at home with her husband until 1 April 2018 when she was admitted to the care home. Prior to her admission, Mrs A had lived with her husband; as her dementia progressed, she increasingly wandered outside of the home both during the day and at night. Mrs A had been reported missing three times to the police, on 3 February 2018, 12 February 2018 and 23 March 2018, being found on each occasion in the town centre. On 23 March 2018, the police found Mrs A in a distressed state; she had fallen and had scrapes and bruising to her head, although it was not clear what had happened. Mrs A was admitted to the local hospital, and although no serious injuries were found, her husband admitted that he could no longer care for her. A social care assessment was completed and subsequently admission to the Dementia Unit of care home was arranged for 1 April 2018.</p> <p>On admission, Mrs A was disorientated and continually wandered around the unit looking for her husband and wanting to go back home, although she did not try to leave the building. The Senior staff member on duty on the morning of her admission, completed the admission documentation and noted Mrs A's behaviours and completed a risk assessment, at this time a DoLS had not been considered. Mrs A had 2 further falls within the home, on 5 and 8 April, and although she didn't appear to be injured, the GP was requested to review her medication, subsequently they arranged for the Falls team to visit. The Falls Team visited on 12 April.</p> <p>Mrs A attempted to leave the care home on 10 May 2018 and an urgent DoLS authorisation was completed by the Care Home Manager and a DoLS request submitted to the Local Authority the same day. Mrs A continuously tried to leave the care home to go home, and staff did support her to go for short walks each day. To ensure her safety, staff were expected to observe Mrs A every 15 minutes and make a note of her location and any presenting behaviours.</p> <p>On the afternoon of 31 August, there were a number of visitors to the home. There had been a new admission (KL) earlier that day and Mr B had been visiting KL. At about 2pm, Mr B was leaving the home and as he opened the door, Mrs A left the building. Staff had observed Mrs A sitting in the lounge area at 12.30, 13.00 and recorded that she was in her room at 13.30.</p>

Staff did not observe Mrs A leaving the building and therefore had not complied with the care plan and risk assessment.

Staff first noticed Mrs A was missing at 2.20pm and carried out a full search of the unit, they contacted the police and reported her missing at 2.45pm. GH (police officer) attended the home and took details.

Mrs A was involved in a road traffic accident at 3.20pm, some 2 miles from the care home. She sadly died later the same day from her injuries.

A Safeguarding Adult Review will only be considered if Section 1 (below) is met **and** Section 2 or 3 are met. Please select all that apply.

1.	There is reasonable cause for concern about how the Teeswide Safeguarding Adults Board, its members or organisations worked together to safeguard this adult.	<input checked="" type="checkbox"/>
2.	The adult died and the Teeswide Safeguarding Adults Board knows/suspects this was as a result of abuse or neglect.	<input checked="" type="checkbox"/>
3.	The adult is still alive but the Teeswide Safeguarding Adults Board knows or suspects the adult has experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.	<input type="checkbox"/>

Please provide key details of this case and outline why you feel that this case meets the criteria for a Safeguarding Adult Review? **YOUR ANALYSIS**

Mrs A died as a result of her injuries. The care home had a care plan, risk assessments and a DoLS authorisation in place and still failed to appropriately protect her from harm. The staff failed to carry out observations as determined by her care plan and failed to notice at the earliest opportunity that she had left the building. Some initial fact finding indicated that the home failed to have robust records and procedures in relation to visitors to the home.

In my opinion Mrs A died as a result of neglect and organisational abuse and several organisations failed to work together to adequately protect her. The care home did not have robust admission procedures, monitoring procedures and did not question whether the placement was appropriate. A number of professionals had visited Mrs A in the care home; GP, Falls assessor, social worker, BIA, however information about the level of risk in relation to Mrs A's wandering had not been addressed or shared.

The home did not have robust visiting procedures and visitors were not aware that some residents may try to leave the building.

SECTION 6: ANY OTHER REVIEWS PENDING OR COMPLETED

(e.g. Serious Incidents, MAPPA, Domestic Homicide, Single Agency/Management Reviews, Children's Serious Case Reviews). Please indicate if you are unaware of any other reviews (do not leave blank).

Police investigation ongoing.

Communication with the Adult/family will be considered by the Business Manager and SAR Sub-Group Chair upon receipt of this Notification

Is the Adult aware of this Notification?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Is the Adult's representative or family aware of this Notification?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

If your organisation is a member of the Teeswide Safeguarding Adults Board, you must ensure that the Board Member is aware of this Notification prior to submission.

Signature	John Smith	Date	14/08/2018
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Admin Use Only	
Notification Received:	
Case Reference:	