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 in accordance with the Teeswide Safeguarding Adults Board Information Sharing Agreement, SAR Policy & Procedures and in the best interests of the adult/adult's family.

Please complete the form as fully as possible, if you cannot complete some sections, please explain why (do not leave blank).

SECTION 1: ABOUT THE ADULT - PLEASE COMPLETE IN FULL						
Full Name	Mrs A					
Date of Birth	01/01/1956	Gender Identity	F	Ethnicity	White - British	
Address	Care Home, Billingham				Post Code	TS00 000
Date of Serious Incident	31/08/2023		Date of Death (if applicable)		31/08/2023	
Cause of Death (if applicable)	Accident					
Location of Abuse / Neglect / Serious Incident(s)		Main Road, Billingham	Location of Death (if applicable)		Tees Hospital	
Does/did the Adult have care and support needs?					Yes ☒ No ☐	
Please describe their care and support needs: Mrs A has dementia which was diagnosed in January 2023 and has been a resident of Care Home Billingham since 1 April 2023.						
Main type of abuse/neglect identified: For more information about types of abuse click here.					Neglect	

Other types (sub-categories) of abuse/neglect identified (please tick as appropriate):					
Discriminatory	Domestic Abuse	Financial	Modern Slavery	Neglect	
☐	☐	☐	☐	☐	
Organisational	Physical	Psychological	Self-Neglect	Sexual	
				Abuse	Exploitation
☒	☐	☐	☐	☐	☐

SECTION 2: ADULT'S REPRESENTATIVE					
Full Name	Mr A			Gender Identity	Male
Relationship to Adult	Husband				
Address	1 The Street, Billingham			Post Code	TS0 000
Tel. Number	01642 123456	Email	N/A		
Is it appropriate to contact this person if a SAR/Review is agreed?			Yes ☒ No ☐ Don't Know ☐		
If no, please explain reasons for this:					

SECTION 3: DETAILS OF THE CASE

This should include a clear factual outline of the concerns being raised. This will enable the SAR Sub-Group to make an informed decision on whether this meets the criteria for a Safeguarding Adult Review. For guidance; an exemplar SAR Notification form is available via https://www.tsab.org.uk/key-information/policies-strategies/

Case Summary – what happened?
(Please include key dates, people, organisations and places where possible)

Mrs A had lived at home with her husband until 1 April 2023 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 2023, 12 February 2023 and 23 March 2023, being found on each occasion in the town centre. On 23 March 2023, 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 2023.

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 on12 April.

Mrs A attempted to leave the care home on 10 May 2023 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.

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.

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.

What concerns do you have about how agencies worked together to safeguard the adult?
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.

Why do you know/suspect that the person's death or serious harm was due to abuse and/or neglect?
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.

Is there anything else you feel that TSAB should be aware of relating to this case?
The home did not have robust visiting procedures and visitors were not aware that some residents may try to leave the building.

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.	☒
2.	The adult died and the Teeswide Safeguarding Adults Board knows/suspects this was as a result of abuse or neglect.	☒
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.	☐

SECTION 4: OTHER AGENCIES INVOLVED*
It is important to complete this section of the form as this will be used to contact the organisations involved for further information.

Full Name	Organisation	Tel. Number	Email	Relationship to Adult
AB	Tees Council	01642	AB@council.gov.uk	Social Work Team Manager
CD	Care Home Billingham	01642	CD@carehome.co.uk	Care Home Manager
EF	GP Practice	01642	EF@gp.net.uk	GP

GH	Cleveland Police	01642	GH@police.uk	Investigating Officer
IJ	Tees Hospital	01642	IJ@hospital.net.uk	Ward Sister
KL	Tees Council	01642	KL@fallsservice.net.uk	Falls Assessor

*please add more rows if necessary

SECTION 5: ANY OTHER REVIEWS/PROCESSES PENDING OR COMPLETED (e.g. Serious Incident, Domestic Homicide, Single Agency/Management Reviews, Child Safeguarding Practice Review, Learning Disability Mortality Review (LEDER), Coroner Investigation, Criminal Enquiry, Complaint, Drug/Alcohol Related Death Review), MAPPA, MARAC, MATAC. Please indicate if you are unaware of any other reviews/processes (do not leave blank).
Police investigation ongoing.

SECTION 6: COMMUNICATION 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	☐	No	☒
Is the Adult's representative or family/carer aware of this Notification?	Yes	☐	No	☒

If your organisation is a member of the Teeswide Safeguarding Adults Board, wherever possible this Notification should be forwarded to the TSAB Business Unit by your agency's Board member.						
Has your organisation's TSAB Member been made aware of this Notification?	Yes	☒	No	☐	My agency is not a member of TSAB	☐

SECTION 7: ABOUT THE PERSON COMPLETING THE FORM			
Full Name	John Smith	Job Title	Service Manager
Organisation	Stockton Council	Relationship to Adult	None
Email	jsmith@council.gov.uk	Telephone Number	01642 100 100
Signature	J Smith	Date	01/09/2023
If there is a delay (more than 4 weeks) between the serious incident and submitting the SAR Notification form, please explain the reason/rationale for this delay: N/A			

Admin Use Only	
Notification Received:	
Case Reference:	

If you are unsure which is the most appropriate review process to refer to, more information about different types of learning reviews can be found here.

Please send the completed SAR Notification form securely to tsab.businessunit@stockton.gov.uk