

Ealing Safeguarding Adult Review
Concerning the death of Reza

Dr. Sarah Hutton, Independent Chair & Safeguarding Consultant

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1. Introduction

This Safeguarding Adults Review (SAR) has been commissioned by the Ealing Safeguarding Adults Board in accordance with Section 44 of the Care Act 2014.[1] The statutory duty to undertake a SAR arises where an adult with care and support needs has died, and there is reasonable cause for concern about how partner agencies worked together to safeguard them.

This Review considers the circumstances surrounding the care and support provided to *Reza* (a pseudonym), a 77-year-old British-Iranian man, with advanced dementia and multiple complex health needs, who died in January 2025. Reza experienced progressive physical and cognitive deterioration over the period under review, including recurrent falls, chronic subdural haemorrhage, pulmonary embolism, urinary retention requiring long-term catheterisation, pressure damage, reduced mobility, weight loss and increasing frailty. His needs became increasingly complex over time, with growing reliance on family members to provide care and supervision within the home environment.

Reza lived at home with his wife and adult children. His wife also had significant health and care needs following a stroke and was in receipt of a formal package of care. In contrast, Reza was not receiving a formal package of care despite increasing dependency and repeated contact with health and social care services. Care was instead largely provided by family members, particularly his son, within the context of escalating physical deterioration and increasing pressure on informal caregiving arrangements.

The Review focuses primarily on the period from July 2024 to January 2025, during which Reza experienced multiple hospital admissions and discharges, increasing involvement from community and urgent care services, referrals to Adult Social Care, and eventual safeguarding escalation. Earlier events have been drawn upon where necessary to understand the wider context, including previous attempts by services to engage the family around support arrangements and care provision.

Particular attention is given to how deterioration, frailty and increasing dependency were recognised and responded to over time, how decisions were made within the context of family caregiving arrangements, and how organisational systems and multi-agency working shaped professional decision-making. Reza's case raises important questions regarding the recognition of cumulative deterioration and hidden risk within family care arrangements, particularly where families appear committed and engaged, but where needs may gradually exceed what can safely be sustained without formal support. It also highlights wider challenges identified in national Safeguarding Adults Reviews, including fragmented oversight across agencies, variation in the interpretation of risk, and safeguarding responses that are triggered by visible crisis points rather than emerging trajectories of concern.[2]

[1] Care Act 2014, s.44 (Safeguarding Adults Reviews). Statutory duty/criteria for SABs to commission SARs. Home: legislation.gov.uk. Care Act 2014

[2] Preston-Shoot, M. (2020) What have we learned from Safeguarding Adults Reviews? London: Local Government Association

2. About Reza

Throughout this Review, Reza remains at the centre of the analysis, consistent with the principles of Making Safeguarding Personal[3]. The Review recognises him not solely through the circumstances of his death or his care needs, but as a person whose experience was shaped by his relationships, cultural context, health needs and the responses of the systems around him. Although the Review was able to develop some understanding of Reza through practitioner accounts and family interactions recorded within agency records, comparatively little information was available regarding his own voice, wishes, routines and lived experience. Much of the available material focuses on deterioration, service involvement and practical caregiving arrangements, reflecting how professional records often prioritise health and care needs over the personal narratives of the individuals they seek to support.

Following circulation of the draft report, Reza's daughter shared her reflections on her father's final months. She described the significant physical and emotional impact of his progressive deterioration, the demands placed upon the family in caring for both parents within the home, and their belief that opportunities to provide earlier support and intervention had been missed. While these reflections could not be independently verified in every respect, they have assisted the Review in better understanding the family's lived experience and the impact that Reza's deterioration and death had upon those closest to him.

What is clear is that Reza remained within a close family environment throughout the period under consideration and that family members played a central role in supporting his day-to-day care as his needs increased over time. Practitioner records and discussion during the learning event reflected a family attempting to support Reza within the home environment in the context of increasingly complex health and care needs. As the Review progressed, it became increasingly apparent that Reza's experience could not be understood solely through individual service contacts or clinical episodes. Rather, his circumstances developed over time within the interaction between progressive deterioration, family caregiving pressures and fragmented system oversight across multiple agencies. This Review therefore seeks not only to understand what happened in the period leading up to Reza's death, but also how Reza's lived circumstances and changing needs were understood and responded to by the systems around him.

3. Methodology

3.1 Purpose

The purpose of this Safeguarding Adults Review is to understand how agencies worked together to support and safeguard Reza, and to identify learning to strengthen future practice. In line with Section 44 of the Care Act 2014, the Review focuses on:

- how deterioration, frailty and increasing dependency were recognised and responded to over time
- how risks associated with family caregiving arrangements, carer strain and increasing complexity were understood and addressed

[3] Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS). (2014). *Making Safeguarding Personal: Guide 2014.* London: LGA.

- how hospital discharge planning, community support and Adult Social Care involvement operated in practice
- how information was shared, understood and escalated across agencies
- how safeguarding thresholds, professional curiosity and escalation processes were applied
- and how mental capacity, best interests and decision-making were considered within the context of increasing risk and dependency.

Also under consideration is the extent to which cultural, family and relational contexts were understood within practice, including how assumptions regarding family willingness or ability to provide care may have influenced professional responses over time. Particular attention is given to the period immediately preceding Reza's final hospital admission, including the management of catheter and pressure care needs, increasing concerns regarding the sustainability of care arrangements within the home, and the escalation of safeguarding concerns in January 2025. The Review does not seek to apportion blame. Its focus is on understanding practice within context and identifying opportunities for system learning and improvement.

3.2 Approach

The Review adopted a systems-based learning approach[4], seeking to understand how professional practice, organisational processes and inter-agency working interacted within the context of Reza's care and support. Rather than focusing on individual error or hindsight judgement, there was an examination of the wider system conditions, pressures and contextual factors that shaped professional decision-making at the time events occurred.

The methodology was designed to support reflective learning and collaborative analysis across agencies; to understand not only what happened, but *why* practice developed in the way it did, including how risk was recognised, interpreted, communicated and responded to across the system over time. The Review was informed by:

- Individual Management Reviews (IMRs) and chronologies submitted by participating agencies
- relevant policies, procedures and safeguarding documentation
- multi-agency records relating to Reza's care, hospital admissions, discharge arrangements and safeguarding responses
- and a multi-agency practitioner learning event facilitated by the independent reviewer.

Participating agencies included:

- Adult Social Care
- London North West University Healthcare NHS Trust
- District Nursing Services

[4] Social Care Institute for Excellence (SCIE). (2022). *Safeguarding Adults Reviews Quality Markers*. London: SCIE.

- London Ambulance Service
- Metropolitan Police Service
- Primary Care
- and relevant community-based services involved in Reza's care and support.

The practitioner learning event brought together representatives from agencies involved in Reza's care to explore emerging findings, reflect on decision-making and test areas of analysis identified within the Early Analysis Report. The discussion was conducted within a psychologically informed and non-blaming learning environment intended to support openness, reflection and professional curiosity. The reviewer is also grateful to Reza's daughter for sharing her reflections during the final stages of the Review. Although received after the practitioner learning event, her contribution has helped strengthen understanding of the family's experience.

3.3 Scope of the Review

The Review focused primarily on the period between July 2024 and January 2025, when concerns regarding deterioration, hospital discharge arrangements, increasing dependency and safeguarding risk became increasingly significant. Earlier agency involvement was also considered where necessary in order to understand the wider context and trajectory of Reza's care and support needs. Consideration was also given to relevant legal and practice frameworks including the Care Act 2014, the Mental Capacity Act 2005, and national safeguarding guidance relating to self-neglect, carer stress, hospital discharge and multi-agency safeguarding practice.

Letters inviting participation were sent to Reza's family during the course of the Review. Although no response was received initially, following circulation of the draft report Reza's daughter contacted the independent reviewer and provided a detailed written account of the family's experiences of health and social care services. Her contribution has been considered in finalising this report. While the information was received after the practitioner learning event and therefore could not be explored with agencies during the Review process, it has provided valuable insight into the family's perspective and has informed the final report where supported by the available evidence.

4. Key Practice Episodes

To support a structured understanding of Reza's care, the Review has been organised into a series of Key Practice Episodes (KPEs). These represent significant points in time where needs changed, risks emerged or escalated, or important decisions were required. The use of KPEs enables the Review to move beyond a purely chronological account and instead focus on critical moments in Reza's care, bringing together information from across agencies and practitioner reflection to understand how practice unfolded within the context of increasing complexity.

Taken together, the KPEs provide a narrative of Reza's care journey, including the interaction between family caregiving arrangements, health deterioration, safeguarding concerns and multi-agency involvement over time:

Table 1: Summary of Key Practice Episodes

KPE	Time Period	Focus	Summary of Issues
KPE 1	July 2024	Initial deterioration, falls and emerging dependency	Reza experienced increasing frailty, falls and reduced mobility alongside advanced dementia and complex health conditions. Services responded to episodes of deterioration, while family members continued to provide the majority of care within the home environment.
KPE 2	July – October 2024	Increasing complexity and reliance on family care	Reza's care needs escalated significantly, including pressure care concerns, catheter management and increasing dependency. Multiple agencies became involved, while concerns regarding the sustainability of family caregiving arrangements and escalating complexity gradually emerged.
KPE 3	October – December 2024	Hospital admissions, discharge planning and Adult Social Care involvement	Reza experienced repeated admissions and discharges alongside increasing professional involvement. Questions emerged regarding discharge planning, coordination of services, responsiveness of Adult Social Care systems and the extent to which cumulative risk was being considered holistically.
KPE 4	December 2024 – January 2025	Escalating safeguarding concerns and increasing care pressures	Concerns regarding pressure care, catheter management, deterioration and care sustainability intensified. Agencies became increasingly concerned about risk within the home environment, while safeguarding thresholds and escalation processes were tested in practice.
KPE 5	January 2025	Final safeguarding intervention, hospital admission and end-of-life care	Safeguarding concerns prompted Reza's final hospital admission. His condition was recognised as significantly deteriorated, and end-of-life care planning became an increasing focus during the final days of his life.

4.1 Understanding the Pattern of Reza's Experience

Taken together, the Key Practice Episodes describe a situation in which Reza's needs became increasingly complex over a relatively short period of time. While each episode reflects specific events, decisions and service responses, when viewed collectively they illustrate a broader pattern of cumulative deterioration, increasing dependency and growing pressure on family caregiving arrangements within the home environment.

Across the period under review:

- Reza experienced progressive physical deterioration alongside advanced dementia and increasing frailty

- family members assumed responsibility for increasingly complex care needs
- multiple agencies became involved at different stages of deterioration and crisis
- and concerns regarding risk, care sustainability and safeguarding emerged incrementally over time.

What is evident across these episodes is that no single issue or event fully explains the trajectory of Reza's experience. Rather, his circumstances developed through the interaction of changing health needs, family caregiving pressures, repeated hospital admissions and discharges, and the involvement of multiple agencies responding to different aspects of risk and need at different points in time.

The following sections draw upon practitioner reflection, agency records and relevant safeguarding literature to explore how these factors were understood and responded to across the system, including the extent to which opportunities existed for earlier coordination, escalation and holistic reassessment of Reza's overall situation.

4.2 Learning from Previous Ealing Safeguarding Adults Reviews

Previous Safeguarding Adults Reviews undertaken within Ealing have identified a number of recurring themes relevant to this Review, particularly in cases involving older adults, dementia, deteriorating health, pressure care concerns and increasing reliance on care within the home environment.

Reviews including *Elsie*, *Piotr* and *John*[5] highlighted recurring challenges relating to:

- recognition of cumulative deterioration and escalating risk
- coordination and oversight across multiple agencies
- safeguarding responses to emerging patterns of harm and neglect
- the interface between formal services and informal or family-provided care
- communication and escalation across organisational boundaries
- and the importance of holistic understanding of an adult's lived circumstances, rather than responding solely to individual presenting incidents.

Several of these reviews also identified the risk that deterioration becomes normalised over time, particularly where adults remain within home environments supported by family members or informal care arrangements. The Reviews highlighted how agencies may respond appropriately to individual episodes or presenting concerns, while opportunities to develop a coordinated understanding of cumulative risk are less consistently realised.

These themes provide important context for understanding Reza's experience and are drawn upon throughout the analysis that follows, enabling consideration of the extent to which learning identified within previous Reviews has been embedded within practice across the local safeguarding system.

[5] Ealing Safeguarding Adults Board (2022) Safeguarding Adults Review: Elsie; Ealing Safeguarding Adults Board (2024) Safeguarding Adults Review: Piotr; Ealing Safeguarding Adults Board (2026) Safeguarding Adults Review: John.

5. Findings

The findings presented below draw on agency records, Individual Management Reviews, chronologies and multi-agency practitioner reflection. The practitioner learning event provided valuable insight into how professionals understood and responded to Reza's circumstances in real time, including the pressures, uncertainties and organisational contexts shaping decision-making.

In line with the purpose of the Review, these findings are not considered in isolation. They are situated within wider learning from Safeguarding Adults Reviews, national safeguarding guidance and relevant research relating to frailty, cumulative deterioration, family caregiving, safeguarding practice and multi-agency coordination. This approach enables the Review to move beyond describing what happened in Reza's case, to consider:

- how practice aligned with previously identified learning
- where similar patterns of challenge are recurring
- and what this suggests about the embedding of learning across the safeguarding system.

Importantly, the findings also recognise examples of committed, thoughtful and compassionate practice identified throughout the Review. Practitioners across agencies were working within a complex and evolving situation involving advanced dementia, repeated deterioration, increasing dependency and significant family caregiving pressures. The findings therefore seek to provide a balanced account, recognising both strengths in practice and opportunities for learning and improvement.

Consistent with national SAR evidence, the issues identified within this Review do not arise from isolated professional actions alone, but from the interaction between organisational systems, communication processes, professional interpretation of risk, and the relational context in which care was being provided.[6]

5.1 Recognition of Deterioration and Cumulative Risk

Agency involvement with Reza increased significantly during the latter half of 2024 as his physical health, mobility and overall level of dependency deteriorated. Records across health and community services describe recurrent falls, worsening frailty, increasing immobility, pressure care concerns, weight loss, urinary retention requiring long-term catheterisation and growing reliance on family members for personal care and supervision within the home environment.

The evidence reviewed by the SAR demonstrates that individual practitioners and agencies were recognising and responding to aspects of Reza's deterioration throughout this period. Ambulance services attended following falls and episodes of deterioration. Hospital teams assessed and treated acute presentations. District Nursing services became increasingly involved in relation to catheter care, wound management and pressure area concerns. Primary Care records reflected ongoing clinical monitoring and contact with the family. Adult Social Care also received referrals associated with increasing need and concerns regarding care arrangements within the home.

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[6] Social Care Institute for Excellence (2020) *Safeguarding Adults Reviews: Analysis of SARs April 2017–March 2019*; Department of Health and Social Care (2022) *Care and Support Statutory Guidance*.

What emerges from the records, however, is that deterioration was often understood and managed through separate episodes of service involvement rather than through a consistently shared understanding of cumulative risk across agencies. Different services were seeing different parts of Reza's experience: acute presentations, falls, discharge needs, catheter care, pressure damage, increasing frailty or concerns regarding care arrangements within the home. While these concerns were individually recognised, there is less evidence that they were consistently drawn together into an overarching multi-agency understanding of escalating vulnerability and care complexity.

This was particularly evident in the period following repeated hospital admissions and discharge episodes during late 2024. When Reza's needs became progressively more complex, there was limited reassessment of whether existing care arrangements remained sustainable in the context of advanced dementia, increasing physical dependency and growing reliance on family-provided care. Practitioners participating in the learning event reflected on the challenges of recognising when gradual deterioration had moved beyond expected progression associated with frailty and dementia into a situation requiring wider safeguarding consideration and coordinated escalation. Several practitioners described the complexity of working within a context where Reza's deterioration had occurred incrementally over time, with no single defining incident initially signalling crisis, but rather an accumulation of concerns emerging across multiple contacts and services.

This pattern is reflected within wider national learning. NICE guidance on frailty highlights that frailty is associated with increased vulnerability to sudden deterioration, loss of independence, hospital admission and adverse outcomes, particularly following acute illness or changes in functioning.[7] The guidance emphasises the importance of holistic assessment and coordinated planning where older adults present with increasing complexity and dependency. Similarly, national analysis of Safeguarding Adults Reviews has repeatedly identified the risk that gradual deterioration becomes normalised over time, particularly where adults remain within family or community settings and where agencies respond primarily to isolated presenting concerns rather than cumulative trajectories of risk.[8]

Previous Ealing Safeguarding Adults Reviews, including *Elsie* and *John*, identified similar challenges regarding fragmented oversight, repeated service involvement and the recognition of escalating risk in older adults with deteriorating health needs.[9] In Reza's case, the Review found evidence of committed professional involvement across agencies, but less evidence of coordinated system oversight regarding the overall trajectory of deterioration. Opportunities existed for earlier holistic reassessment of Reza's changing needs and care arrangements, particularly in the context of repeated deterioration, increasing frailty and escalating reliance on informal family care. This finding does not arise from isolated professional failings, but from the cumulative effect of multiple agencies responding to different aspects of need without a sufficiently shared understanding of the broader trajectory of developing risk.

[7] National Institute for Health and Care Excellence (2016) *Multimorbidity: clinical assessment and management (NG56).* London: NICE.
[8] Preston-Shoot, M. (2020) *What have we learned from Safeguarding Adults Reviews?* London: Local Government Association.
[9] Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*; Ealing Safeguarding Adults Board (2026) *Safeguarding Adults Review: John.*

5.2 Family Caregiving, Carer Strain and the Sustainability of Care Arrangements

A central feature of Reza's care throughout the review period was the extent to which responsibility for meeting increasingly complex needs rested with family members within the home environment. Although Reza's wife was in receipt of a formal package of care following a stroke, Reza himself was not receiving an equivalent package of support despite progressive deterioration, increasing dependency and repeated involvement from health and community services.

The records reviewed by the SAR consistently describe family members, particularly Reza's son, as heavily involved in supporting his day-to-day care. This included supervision associated with dementia, support with mobility and transfers, continence care, catheter management, attendance at appointments and responding to periods of deterioration. Practitioners across agencies generally experienced the family as engaged and committed to maintaining Reza at home. There is evidence throughout the records of family members seeking assistance, communicating with professionals and attempting to manage increasingly complex care responsibilities within the household. At the same time, the evidence also demonstrates growing pressure within the care arrangements. As Reza's needs escalated, the practical and emotional demands placed upon family members appear to have increased significantly. The household was supporting two adults with substantial care needs, within the context of advanced dementia, reduced mobility, pressure care concerns and increased deterioration requiring professional intervention.

The Review heard evidence during the practitioner learning event that concerns regarding the sustainability of care arrangements were emerging gradually across services during late 2024 and early 2025. Practitioners reflected that, while individual agencies recognised increasing complexity, there was uncertainty at times regarding the extent to which family members were coping, what support was realistically sustainable within the home environment, and how concerns regarding carer strain should be understood or escalated where family members continued to express commitment to caring for Reza at home.

Records also suggest that discussions regarding formal care provision may have been influenced by anxiety relating to charging arrangements and the implications of accepting services. Practitioners described difficulties in fully understanding the family's views regarding support, including whether reluctance related primarily to financial concerns, cultural expectations regarding family caregiving, communication barriers, mistrust of services, or a combination of factors. While aspects of these issues were recognised by individual practitioners, there is limited evidence that they were explored consistently across agencies. The family's subsequent contribution reinforced the extent to which they experienced caring responsibilities as becoming increasingly overwhelming, while also expressing concerns that services did not fully appreciate the cumulative impact of Reza's deteriorating needs upon the household.

The practitioner learning event also prompted reflection regarding whose voice was being heard within the family system and how this may have influenced professional understanding of the care arrangements. While much of the communication with services appears to have occurred through Reza's daughter, records suggest that a significant proportion of day-to-day caring responsibilities rested with his son. Practitioners reflected on whether opportunities existed for more direct engagement with those undertaking the majority of caregiving tasks, in order to better understand the practical realities of caring, and barriers to accepting support.

The Care Act 2014 and accompanying statutory guidance emphasise the importance of recognising carers as individuals with needs in their own right, including consideration of the sustainability of caring arrangements and the potential impact of caring responsibilities on wellbeing.[10] National safeguarding learning has similarly highlighted the complexity of situations in which families continue to provide significant care despite escalating need, particularly where deterioration occurs gradually and where family commitment may mask increasing strain or reduced capacity to safely manage risk.[11]

Previous Ealing Safeguarding Adults Reviews have identified the risk that strong family involvement can unintentionally lead agencies to overestimate the sustainability of informal care arrangements or underestimate the extent of unmet need developing within the home.[12] In Reza's case, the Review found evidence of thoughtful and compassionate professional engagement with the family, but less evidence of coordinated reassessment regarding whether the overall care arrangements remained safe and sustainable as Reza's condition deteriorated.

The practitioner learning event reflected significant professional reflection regarding the balance between respecting family wishes and recognising when escalating dependency and complexity may require more assertive multi-agency intervention or reassessment. Practitioners described the challenges of navigating situations where families appeared committed and engaged, while concerns regarding Reza's care were simultaneously emerging across the system. The Review therefore finds that greater multi-agency focus was required regarding the sustainability of family caregiving arrangements as Reza's needs increased. In particular, there were opportunities for earlier holistic reassessment of carer strain, clearer exploration of barriers to accepting formal support, and more coordinated consideration of whether existing care arrangements continued to safely meet Reza's changing needs.

5.3 Hospital Discharge, Coordination of Care and System Oversight

Repeated hospital admissions and discharges formed a significant feature of Reza's experience during the review period. Records demonstrate increasing involvement from acute hospital services alongside community nursing, primary care, ambulance services and Adult Social Care as Reza's health and care needs became progressively more complex. The Review identified a number of points at which discharge planning and coordination of care required agencies to consider not only Reza's immediate clinical needs, but also the sustainability of care arrangements within the home environment following discharge. This included consideration of mobility, pressure care, catheter management, supervision associated with dementia and the capacity of family members to safely manage increasingly complex care responsibilities. The family also described their concerns that opportunities to address Reza's deteriorating swallowing, nutrition and overall physical decline had been missed.

Hospital records demonstrate that practitioners were aware of significant frailty, recurrent falls and increasing dependency during admissions in late 2024. There is evidence that referrals were made to community services and Adult Social Care, and that agencies were attempting to coordinate ongoing support following discharge. However, there was limited evidence of a consistently shared multi-

[10] Department of Health and Social Care (2022) *Care and Support Statutory Guidance.* London: DHSC.
[11] Braye, S., Orr, D. and Preston-Shoot, M. (2015) *Serious Case Review Findings on the Challenges of Self-Neglect.* London: Local Government Association
[12] Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*; Ealing Safeguarding Adults Board (2024) *Safeguarding Adults Review: Piotr*

agency understanding regarding how repeated admissions, ongoing deterioration and escalating care complexity were affecting the overall sustainability of care within the home. While services frequently responded to immediate presenting concerns and arranged follow-up support within their own professional remit, oversight of the broader trajectory of deterioration appears to have remained fragmented across organisational boundaries.

Practitioners participating in the learning event reflected on the complexity of discharge planning in circumstances where Reza and his family consistently expressed a wish for him to remain at home, despite increasing levels of need and dependency. Professionals described the challenges of balancing respect for family wishes and autonomy with concerns regarding safety and the practical realities of providing complex care within the home environment. There was uncertainty at times regarding professional ownership and coordination; multiple agencies became involved in different aspects of Reza's care, including tissue viability concerns, catheter management, falls, continence support and safeguarding referrals. However, there was less clarity regarding which service retained overall oversight of the developing situation or responsibility for coordinating reassessment as needs escalated.

National guidance emphasises that discharge planning for adults with frailty, dementia and complex care needs should involve coordinated multi-agency assessment, clear communication and ongoing review of whether care arrangements remain safe and sustainable following discharge.[13] Research and national safeguarding learning have similarly highlighted the heightened vulnerability associated with repeated discharge cycles, particularly where adults experience cumulative deterioration across multiple services and settings.[14] Previous Ealing Safeguarding Adults Reviews have identified comparable themes regarding fragmented oversight and the challenges of coordinating care for adults with increasingly complex needs across hospital and community settings.[15]

The practitioner learning event reflected considerable professional reflection regarding whether opportunities existed for earlier multi-agency escalation or more coordinated reassessment following repeated admissions and discharge episodes. Practitioners particularly reflected on how cumulative deterioration can become obscured where services are focused primarily on resolving immediate clinical presentations and arranging short-term discharge support. As Reza's condition deteriorated during late 2024 and early 2025, practitioners also reflected on the extent to which his presentation increasingly reflected an end-of-life trajectory associated with advanced frailty, dementia and cumulative physical decline. Reza experienced repeated admissions, progressive immobility, increasing dependency, pressure care concerns, recurrent infection-related complications and significant weight loss within a relatively compressed period. While individual clinical needs were being actively managed, there was less evidence of coordinated anticipatory care planning or explicit multi-agency discussion regarding how safeguarding concerns, deteriorating health and end-of-life considerations should be understood together within the context of his overall care journey.

National guidance emphasises the importance of recognising deterioration and frailty early within older adults experiencing complex health decline, including the need for coordinated anticipatory care planning, multidisciplinary communication and involvement of families in discussions regarding future care needs and risks.[16] The Review heard professional reflection regarding whether earlier

[13] Department of Health and Social Care (2020) *Hospital Discharge Service: Policy and Operating Model.* London: DHSC.
[14] British Geriatrics Society (2014) *Fit for Frailty: Consensus Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient Settings.* London: BGS.
[15] Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*; Ealing Safeguarding Adults Board (2026) *Safeguarding Adults Review: John*.
[16] British Geriatrics Society (2014) *Fit for Frailty: Consensus Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient Settings.* London: BGS.

recognition of Reza's likely end-of-life trajectory may have supported more proactive coordination across services and reduced reliance on repeated reactive intervention during the final stages.

Discharge episodes represented important opportunities for reassessment of Reza's changing needs and care arrangements. While agencies were actively involved in responding to presenting needs, opportunities existed for greater multi-agency coordination and more explicit consideration of the long-term sustainability of care within the home environment. Practitioner discussion also reflected uncertainty regarding the timeliness and responsiveness of Adult Social Care processes during periods of escalating deterioration, particularly where referrals were being considered individually rather than within the context of cumulative risk emerging across agencies.

5.4 Safeguarding Thresholds, Professional Curiosity and Escalation

Safeguarding concerns relating to Reza's care became increasingly prominent during January 2025, when community nursing staff raised concerns regarding the home environment, pressure care, catheter management and the overall condition in which he was being cared for. These concerns ultimately contributed to Reza's final hospital admission. Agency records demonstrate that practitioners across services had identified aspects of escalating risk and deterioration over a longer period. However, these concerns developed across multiple services and contacts rather than through a single incident that clearly triggered coordinated safeguarding intervention at an earlier stage.

Practitioners participating in the learning event reflected on the complexity of recognising when concerns associated with frailty, family caregiving pressures and deteriorating health should move beyond care management or clinical response into formal safeguarding escalation. Several described uncertainty regarding thresholds, particularly where family members appeared engaged and committed to supporting Reza at home, and where deterioration could potentially be understood through multiple lenses simultaneously: progression of illness, carer strain, reduced capacity to cope, or possible neglect associated with increasingly complex care needs. During the weeks preceding Reza's final admission, District Nursing involvement intensified in response to pressure care and catheter concerns, while practitioners recorded increasing unease regarding the home environment and Reza's presentation. The safeguarding referral made in January 2025 reflected a point at which concerns and escalating risk had moved beyond what practitioners considered manageable through routine service intervention alone.

National safeguarding guidance emphasises that safeguarding concerns may arise not only through deliberate acts of abuse, but also through situations involving carer breakdown, neglect associated with inability to cope, organisational complexity or cumulative unmet need.[17] National SAR learning has similarly highlighted the risk that safeguarding responses may be delayed where deterioration develops gradually over time, particularly in situations involving family caregiving arrangements and complex health deterioration.[18]

The Review also considered whether opportunities existed for greater professional curiosity and earlier multi-agency escalation as Reza's needs became increasingly complex. Professional curiosity does not require practitioners to assume malicious intent or blame within families. Rather, it involves maintaining reflective uncertainty, exploring whether explanations fully account for emerging

[17] Department of Health and Social Care (2022) *Care and Support Statutory Guidance.* London: DHSC.
[18] Preston-Shoot, M. (2020) *What have we learned from Safeguarding Adults Reviews?* London: Local Government Association.

concerns, and considering whether escalating needs and risks are being sufficiently recognised across the system.[19]

Previous Ealing Safeguarding Adults Reviews have identified similar themes regarding the gradual normalisation of deteriorating circumstances and uncertainty regarding safeguarding thresholds in cases involving older adults with complex care needs.[20] Reza's case demonstrates how concerns may become increasingly visible across agencies over time without immediately translating into coordinated safeguarding escalation, particularly where aspects of care arrangements continue to appear functional despite growing underlying fragility. There was significant professional reflection regarding whether opportunities existed for earlier multi-agency discussion as Reza's dependency, frailty and pressure care needs increased during late 2024.

5.5 Mental Capacity, Decision-Making and the Balance Between Autonomy and Risk

Questions relating to mental capacity, autonomy and decision-making were present throughout Reza's care, particularly as his frailty increased during the latter part of 2024. Agency records demonstrate that practitioners across services recognised Reza's diagnosis of advanced dementia and his growing reliance on family members to support communication, personal care, daily living and engagement with services. However, there was limited evidence of explicit consideration regarding Reza's capacity to make specific decisions during the period under review. While his dementia and increasing reliance on family members were widely recognised, there was limited evidence of structured discussion regarding which decisions Reza remained able to make for himself, which decisions required formal assessment, and how his views and preferences were being elicited as his condition deteriorated. The Mental Capacity Act 2005 begins with the presumption of capacity and requires decision-making ability to be considered on a decision-specific basis rather than assumed on the basis of diagnosis alone. As a result, there was limited evidence that Reza was consistently positioned as the primary decision-maker in relation to specific decisions affecting his care, treatment or living arrangements before responsibility increasingly shifted towards family members and professionals.

As Reza's condition deteriorated, professionals were increasingly required to navigate complex questions regarding risk, autonomy, family caregiving arrangements and the sustainability of care within the home environment. Records demonstrate ongoing attempts by practitioners to work collaboratively with the family and to support Reza remaining at home in accordance with family wishes. However, the Review found less evidence of explicit multi-agency discussion regarding how increasing frailty, pressure care concerns, repeated deterioration and escalating dependency should influence reassessment of risk and 'best interests decision-making over time.

Much of Reza's communication with services increasingly occurred through family members as his dementia progressed. This was understandable within the context of his deteriorating cognition and reliance on those closest to him. However, it also created complexity for practitioners attempting to balance respect for family involvement with the need to independently assess Reza's presentation, wishes, safety and changing care needs. The family's subsequent account also reflected their perception that decisions increasingly took place around Reza rather than with him as his dementia

[19] Social Care Institute for Excellence (2018) *Professional Curiosity: Resource for Safeguarding Adults.* London: SCIE.
[20] Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*; Ealing Safeguarding Adults Board (2024) *Safeguarding Adults Review: Piotr*.

progressed. This reinforces the importance of ensuring that Mental Capacity Act principles remain central to practice, with adults supported to participate in decision-making wherever possible and formal capacity assessments undertaken when required. Practitioners participating in the learning event reflected on the difficulty of working within circumstances where concerns regarding care sustainability were gradually increasing, while family members continued to express commitment to maintaining Reza at home.

There were also concerns relating to restrictive practice during the final stages of Reza's care, including reports that family members had attempted to prevent him from removing medical devices. Practitioner discussion during the learning event highlighted the complexity of interpreting these actions within the context of advanced dementia, repeated catheter removal, significant physical deterioration and escalating carer strain. Participants reflected that the actions appeared to arise within a context of family members attempting to manage increasingly complex clinical risks at home, rather than evidence of intentional harm. At the same time, there was limited evidence of structured multi-agency discussion regarding restrictive practice, proportionality, least restrictive options or formal best interests decision-making as risks escalated and supervision needs increased. This included how the family could be supported to safely manage behaviours associated with advanced dementia.

Practitioner discussion highlighted the challenges of balancing autonomy, dignity, safety and least restrictive practice in the context of advanced dementia and increasing dependency. The Review heard reflection regarding whether earlier multidisciplinary discussion may have assisted in developing a shared approach to managing these risks, particularly where family members were attempting to respond to increasingly complex care needs within the home environment. The Review also heard reflection regarding whether increasing supervision needs, restrictions associated with safety management and reliance upon family oversight warranted more explicit consideration of deprivation of liberty principles as Reza's condition deteriorated.

The Review also noted evidence that practitioners were discussing future decision-making arrangements during the latter stages of Reza's deterioration, including conversations regarding Lasting Power of Attorney and advance care planning. However, the Review found limited evidence of a coordinated multi-agency understanding regarding the status of any Lasting Power of Attorney arrangements, who was authorised to make decisions on Reza's behalf where capacity was lacking, or how best interests decision-making should be coordinated across agencies. Practitioner discussion suggested that these issues were recognised by individual services but were not brought together into a shared legal and practice framework as Reza's needs became increasingly complex.

Several practitioners described uncertainty regarding when deteriorating circumstances should trigger a formal best interests discussion, safeguarding escalation or reassessment of whether existing care arrangements remained appropriate and safe. The Mental Capacity Act 2005 Code of Practice emphasises that capacity assessments should be decision-specific and responsive to changing circumstances, particularly where illness, cognitive impairment, infection or fluctuating presentation may affect decision-making over time.[21] The Code also makes clear that best interests decision-making should include consideration of the person's wishes, feelings, beliefs and values, while ensuring that decisions appropriately account for safety, wellbeing and the least restrictive available options.

[21] Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice.* London: The Stationery Office.

NICE guidance on dementia similarly highlights the importance of ongoing reassessment and multidisciplinary working as needs become increasingly complex, particularly where individuals are dependent upon family members for care and communication.[22] The guidance recognises that dementia care often requires practitioners to work relationally with families while remaining attentive to safeguarding concerns, changing levels of need and the adult's own experience within the care environment.

There was certainly evidence of compassionate and well-intentioned practice across agencies, with practitioners frequently attempting to balance respect for family wishes and cultural context with concerns regarding Reza's deteriorating condition. However, there was less evidence of explicit multi-agency discussion regarding how increasing frailty, pressure care concerns, repeated deterioration and escalating dependency should influence reassessment of risk, mental capacity, best interests decision-making and ongoing care arrangements over time. Previous Ealing Safeguarding Adults Reviews have identified similar challenges in cases involving older adults with deteriorating health and increasing reliance on family care arrangements, particularly where agencies are attempting to balance least restrictive practice with emerging safeguarding concerns and growing complexity within the home environment.[23]

Opportunities existed for more explicit and coordinated multi-agency consideration of mental capacity, best interests and risk as Reza's needs became increasingly complex. In particular, there was scope for clearer multidisciplinary reflection regarding how escalating frailty, dementia, pressure care concerns and increasing dependency should inform decision-making about ongoing care arrangements and intervention within the home environment.

5.6 Cultural Context, Communication and Understanding Family Experience

The Review considered the extent to which cultural, relational and family contexts were understood within professional practice, particularly in relation to family caregiving arrangements, communication with services and engagement around formal support. Reza was an older Iranian man living within a close family environment in which family members played a central role in providing care and support. Throughout the records reviewed by the SAR, practitioners consistently described family members as highly involved in Reza's care and committed to maintaining him within the home environment. Family members frequently acted as the primary point of communication with services, supported attendance at appointments and were closely involved in day-to-day decision-making regarding Reza's care needs. There was evidence that many practitioners were attempting to work respectfully and collaboratively with the family, including recognising the importance of cultural and family dynamics, and the significance of maintaining Reza within the home environment for as long as possible.

There was uncertainty at times regarding whether reluctance to accept additional support reflected cultural expectations regarding caring responsibilities, anxiety regarding financial implications, concerns about external involvement in family life, communication barriers, or a combination of these factors. Practitioners often relied upon family members to facilitate communication and

[22] National Institute for Health and Care Excellence (2018) *Dementia: assessment, management and support for people living with dementia and their carers (NG97).* London: NICE.
[23] Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*; Ealing Safeguarding Adults Board (2026) *Safeguarding Adults Review: John*.

engagement with Reza, particularly as his dementia progressed. While this was understandable in the context of advanced cognitive impairment, there was less evidence of structured consideration regarding whether additional communication support, culturally informed engagement or independent exploration of the family's understanding of services may have assisted in developing shared understanding regarding risks, support options and care planning.

Research highlights that dementia care within ethnically diverse communities may involve differing expectations regarding family caregiving, support-seeking and engagement with formal services, making culturally informed and relational practice particularly important.[24] The Care Act 2014 similarly emphasises the importance of person-centred practice that takes account of an individual's cultural and relational context when assessing needs, risks and wellbeing.[25]

The Review identified the importance of understanding how cultural context, family caregiving arrangements, communication patterns and perceptions of statutory services may interact with safeguarding practice, engagement and decision-making over time. Previous Ealing Safeguarding Adults Reviews[26] have identified similar themes regarding the importance of culturally informed safeguarding practice and the risks associated with assumptions about family functioning or care arrangements within diverse communities. These Reviews highlighted the need for professional curiosity, reflective discussion and culturally competent engagement that avoids both stereotyping and over-reliance on apparent family resilience.

The practitioner learning event reflected thoughtful professional reflection regarding how practitioners can respectfully engage with family caregiving arrangements while remaining attentive to safeguarding risk, unmet need and increasing care complexity. Practitioners also reflected on the importance of creating opportunities for open conversations about support needs, financial concerns and the realities of providing increasingly complex care within the home environment. Opportunities existed for more explicit exploration of cultural, relational and communication factors throughout Reza's care. In particular, there was scope for more coordinated and culturally informed engagement regarding family understanding of services and barriers to accepting assistance.

6. Good Practice

Throughout the review period, the SAR identified significant examples of thoughtful and professionally committed practice across agencies involved in Reza's care. Practitioners across health, community and safeguarding services were working within a highly complex situation involving advanced dementia, increasing frailty, repeated deterioration and growing pressure on family caregiving arrangements. Practitioners consistently sought to support Reza to remain within his home, in line with the wishes expressed within the family and the principles of least restrictive practice. Across agencies, professionals demonstrated ongoing commitment to responding to Reza's changing needs through repeated assessments, home visits, hospital treatment, community follow-up and attempts to coordinate support.

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[24] Race Equality Foundation (2018) *Better Health Briefing 46: Dementia and Ethnicity.* London: Race Equality Foundation.
[25] Department of Health and Social Care (2022) *Care and Support Statutory Guidance.* London: DHSC.
[26] Ealing Safeguarding Adults Board (2024) *Safeguarding Adults Review: Piotr*; Ealing Safeguarding Adults Board (2022) *Safeguarding Adults Review: Elsie*.

District Nursing services demonstrated persistent involvement in responding to Reza's escalating physical health needs, including catheter care, pressure area management and wound monitoring. Practitioners showed continued professional curiosity regarding changes in Reza's presentation and the condition of the home environment, with increasing concerns appropriately escalated during January 2025 when agency records show risks appeared to be intensifying. Hospital practitioners responded to repeated episodes of deterioration and provided ongoing assessment and treatment within the context of significant frailty and complex health needs. Records demonstrate attempts to involve community services and Adult Social Care within discharge planning processes, alongside recognition that Reza's care needs were becoming increasingly complex over time.

The Review also identified examples of compassionate engagement with Reza's family across services. Practitioners recognised the central role they played in supporting Reza's day-to-day care. During the practitioner learning event, professionals demonstrated thoughtful reflection regarding the challenges of balancing respect for family caregiving arrangements with increasing concerns regarding risk, care sustainability and safeguarding.

Importantly, the practitioner learning event itself reflected strong multi-agency engagement and openness to reflective learning. Practitioners participated constructively and demonstrated willingness to explore complex questions regarding escalation, coordination, safeguarding thresholds and professional decision-making. The Review heard considerable reflection from practitioners regarding how systems and organisational processes shaped practice, alongside genuine commitment to identifying learning to strengthen future safeguarding responses. Many of the challenges identified within Reza's case arose not from a lack of professional concern or effort, but from the complexity of responding to cumulative deterioration and escalating care needs across multiple agencies and settings over time. The examples of professional commitment, persistence and reflective practice identified throughout the Review provide an important foundation upon which future learning and improvement can build.

7. Recommendations

The recommendations arising from this Review are intended to support strengthening of multi-agency safeguarding practice across the Ealing Safeguarding Adults Board partnership. They are designed to build upon existing areas of good practice while addressing the systemic learning identified through the Review. Consistent with the systems-learning approach underpinning this SAR, the recommendations focus not on isolated professional actions, but on strengthening organisational coordination, professional reflection, safeguarding oversight and responses to cumulative deterioration and increasing complexity within community settings.

Recommendation 1: Strengthening Recognition of Cumulative Deterioration and Escalating Risk

The Safeguarding Adults Board should seek assurance from partner agencies regarding how cumulative deterioration, repeated service contact and escalating dependency are recognised and escalated within practice, particularly in cases involving frailty, dementia and increasing reliance on informal family care arrangements. This should include consideration of mechanisms for convening multi-agency review or discussion where repeated deterioration, increasing dependency and safeguarding concerns are emerging across multiple services over time.

This should include:

- consideration of how repeated presentations across services are brought together into shared understanding of risk
- opportunities for earlier multi-agency discussion where deterioration is emerging incrementally over time
- and practitioner support regarding recognition of cumulative safeguarding concerns beyond discrete crisis events or incidents.

Recommendation 2: Multi-Agency Oversight of Complex Family Care Arrangements

The Safeguarding Adults Board should work with partner agencies to strengthen approaches to assessing and reviewing the sustainability of family caregiving arrangements where adults present with increasingly complex health and care needs.

This should include assurance regarding:

- consideration of carer strain and care sustainability within assessment and review processes
- clearer multidisciplinary discussion regarding when existing arrangements may no longer safely meet need
- and culturally informed engagement with families regarding barriers to accepting support, including communication, trust and concerns regarding formal care provision or charging arrangements.

Recommendation 3: Hospital Discharge and Escalation Pathways

Partner agencies should review how discharge planning processes identify and respond to cumulative safeguarding concerns for adults with frailty, dementia and complex care needs who experience repeated admissions and discharges.

This should include:

- clarity regarding professional oversight and coordination following discharge
- escalation pathways where concerns exist regarding care sustainability within the home environment
- opportunities for holistic reassessment following repeated presentations or deterioration
- clearer escalation pathways where community clinicians identify increasing concerns relating to pressure care, continence management, catheter care or deteriorating home care arrangements.

Recommendation 4: Mental Capacity, Best Interests and Escalating Risk

The Safeguarding Adults Board should seek assurance regarding how partner agencies support practitioners to apply Mental Capacity Act principles within situations involving cumulative deterioration, family caregiving complexity and escalating safeguarding concerns.

This should include:

- multidisciplinary reflection regarding fluctuating or changing presentation over time
- timely and decision-specific mental capacity assessments where concerns arise regarding an adult's ability to make decisions about care, residence, treatment or risk
- clearer recording and discussion of best interests considerations, decision-making authority and Lasting Power of Attorney arrangements within complex care situations
- consideration of restrictive practice and deprivation of liberty principles where supervision, control or safety measures become increasingly significant
- and practitioner confidence in balancing autonomy, least restrictive practice and safeguarding responsibilities where risks are progressively increasing.

Recommendation 5: Embedding Learning from Safeguarding Adults Reviews

The Safeguarding Adults Board should consider how learning from previous Ealing Safeguarding Adults Reviews relating to frailty, cumulative deterioration, safeguarding escalation and family caregiving arrangements is disseminated, revisited and embedded across agencies.

This should include:

- opportunities for reflective multi-agency learning
- thematic learning relating to older adults, dementia and complex care arrangements within community settings
- and mechanisms for evidencing how learning from SARs informs operational safeguarding practice over time.