Telford and Wrekin Safeguarding Adults Review (SAR)

Patricia

February 2024 Overview Report

SAR Independent Author: Simon Steel

Report completed: 16th August 2025

This Safeguarding Adult Review would not have been possible to undertake without the co-operation, open reflection and information supplied by those agencies who provided care and support for Patricia. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board managers and support staff have been invaluable throughout this process.

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1 Introduction and Background

1.1 Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.2 The Telford and Wrekin Safeguarding Partnership (TWSP) has accepted the request for a Safeguarding Adult Review (SAR) to be conducted into the circumstances surrounding the death on the 14th of February 2024 at a hospital part of the Shrewsbury and Telford Hospital NHS Trust. At the time of her death Patricia was 74 years of age.

1.3 The SAR panel agreed that the situation met the Care Act Safeguarding criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk.

1.4 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity. The principles apply to the Review as follows:

Empowerment:	The Review will seek to understand how the agencies listened to/heard and engaged with Patricia and applied Making Safeguarding Personal. Involving Patricia's family in the Review.
Prevention:	The learning will be used to consider actions for prevention of future harm to others, particularly in relation to holistic, person-centred planning.
Proportionality:	Understanding whether least restrictive and person-centred practice was used; being proportionate in carrying out our Review objectively.
Protection:	The learning will be used to inform ways of working, actions and professional curiosity to protect others from harm.
Partnership:	Partners will seek to understand looking through the lens of person-centred working, how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process.

Glossary

Name	Abbreviation
Body Mass Index	BMI
District Nurses	DN
Early Intervention Care Team	EICT
Electronic Patient Records	EPR
Emergency Department	ED
Making Safeguarding Personal	MSP
Mental Capacity Assessment	MCA
Mental Health Liaison Service	MHLS
Next Of Kin	NOK
Package of Care	POC
Tissue Viability Nurse	TVN

2 The Purpose of the Review

2.1
- Establish what lessons can be learned from the Patricia's story
- Analyse how organisations work together
- Analyse and expand upon the findings of the various reports

- Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes, or policy

- Facilitate a practitioner's event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented

2.2 This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of Patricia in the weeks and months prior to her death on the 14th of February 2024.

3 What do we know about Patricia.

3.1 Patricia was a white woman, born in 1949 in South Africa. Her daughter Christine identified that Patricia had been in this country since 2016 and had been bedbound since 2020.

3.2 Patricia had complex health challenges which included:

- High Body Mass Index (BMI) (weight 07.10.2023 recorded as 160kg, last recorded BMI 67.3 in Dec 2022)
- Congestive Obstructive Pulmonary Disease (COPD)
- AF (Atrial Fibrillation)
- CCF (Congestive Cardiac Failure)
- Type 2 Diabetes
- Hyperparathyroidism[1]
- Lymphoedema[2]

Patricia had full care and support needs in respect of personal care, toileting, and hygiene, moving and handling, positioning and care was provided by family members. There was no known formal Package of Care (POC) in place.

3.3 Collectively combined these diagnoses and challenges had a significant impact on Patricia's life, resulting in Patricia being bedbound since 2020.

4 Methodology and Process Information

4.1 The author was appointed to undertake the SAR in December 2024.

Organisations Involved

4.2 Combined chronologies were completed by all agencies involved. Individual Management Reviews (IMR) were supplied by 4 agencies identified below and 2

[1] Hyperparathyroidism - NHS
[2] Lymphoedema - NHS

agencies supplied reports to the author completed by a safeguarding adult lead from the organisations involved. The agencies involved included:

- Primary Care (GP) IMR
- Adult Social Care (ASC) IMR
- Shrewsbury and Telford Hospitals Trust (SaTH) IMR
- Shropshire Community Health NHS Trust (SCHT) IMR
- Midlands Partnership University NHS Foundation Trust (MPFT) Report
- West Midlands Ambulance Service (WMAS) Report

4.3 The SAB wrote to Patricia's family on a number of occasions. The SAB did not receive a reply however the GP panel member knows the family in her GP role and kindly reached out on behalf of the review.

4.4 Christine confirmed to the GP that she had received letters about the SAR. However, for a number of reasons both her and the family didn't wish to participate.

4.5 Christine said her mum was a very private person and wouldn't allow anyone but her 2 daughters to do any personal care. She did allow her daughters to wash her and put cream on her intimate areas several times a day but would not allow outside carers to give personal care.

4.6 Following the initial review of all the information, a number of key lines of enquiry (KLE) were identified.

1. Patricia's care was predominantly provided by her daughter Christine.

- Was a carers assessment considered and undertaken?
- Had Christine appropriate training in safe ways to move her mum, care for her skin wounds?
- What support did Christine have in terms of respite?
- Were their other pressures Christine was under alongside her role as carer?
- Was anyone else involved in Patricia's care (to assist Christine)

2 Did Patricia's immigration status have an impact in her decision making with regards to care?

- Were there other funding options available to be explored?

3 Was the manner of her death predictable?

4 Were the signs of self-neglect recognised by all staff and what action had been taken?

5 What is the process when skin wounds are not improving when managed at home?

5. Edited Chronology and Summary

5.1 In order to better understand the interactions between the various agencies and departments involved in the care of Patricia, the author produced a combined chronology. This provides a timeline of events and describes the contact and care that took place prior to her death. Some of the **key** entries are summarised below within the scoping period 01.08.2023 to 15.02.2024 however prior to the scoping period significantly it is useful to understand some history.

5.2 The first involvement with Telford and Wrekin Adult Social Care is in 2021. This is the first point at which the extent of Patricia's bariatric care needs becomes apparent. There is little detail on the record regarding the history of Patricia. There are no expressed Adult Safeguarding Concerns or referrals during this episode. At the point of the recording above she was being supported through enablement funding at a residential placement in Telford, following an admission to PRH (Princess Royal Hospital, Telford). However, she was a Stafford resident and ongoing responsibility regarding care arrangements would be with Stafford at the end of the enablement period not Telford. Patricia self-discharged from the enablement placement. Discussions were held between ASC, Patricia and Christine as advocate. They expressed a wish to return home, with any care needs to be addressed by the family. Patricia was considered to have capacity regarding this decision. Telford and Wrekin ASC liaised with Stafford ASC regarding ongoing care as Patricia was a Stafford resident.

5.3 MPFT first Initial contact was in August 2021 confirms what we know from ASC. Patricia had been discharged from hospital following a fall, into a care home and was now staying with Christine in Staffordshire. Patricia was unable to stand or transfer, had oedematous legs and was using a downstairs hospital bed. OT provided same day assessment of transfers, Patricia was unable to achieve this, therefore recommended a care package with 2 carers ('double-up') Christine was present at this assessment and was able to see Patricia was unable to stand or transfer. In follow-up, Christine explains to the physiotherapist that she has done bed exercises provided with Patricia, apart from sitting on the edge of the bed. Patricia did decline active therapy at points, saying she did not feel up to it, pain management was discussed and reviewed. Physiotherapy notes state Christine had informed that home care had finished after a week as they were not entitled to public funds.

5.4 October 2023

SaTH on the 5th Patricia attended ED with pyrexia (a fever) and confusion. Self-neglect was identified by staff in ED and a safeguarding concern was raised. She was admitted for a period of inpatient care. Christine was noted as the main carer at that time. Patricia was aware of the concern being raised. Patricia was subsequently admitted as an inpatient and had referrals to the Trust Tissue Viability Nurse (TVN) in respect of multiple areas of skin damage including a skin tear beneath her right breast, moisture damage to her groin and left sided moisture damage. During Patricia's admission she was also reviewed under the care of the occupational

therapy team who liaised with Christine who identified she had Bariatric Equipment at home (Bed and Airwave mattress). At the time Christine identified that Patricia was nursed in bed. The Trust discussed the need for a package of care to support discharge, but this was declined by both Christine and Patricia. Patricia was discharged home on the 13th. During this period of admission Patricia was treated for cellulitis. She was also catheterised, and referrals were made to the District Nurses (DN) for ongoing catheter care.

ASC on the 7th a safeguarding contact was received having been referred by **SaTH** the referral states 'unintentional' self-neglect. Referral states capacity to make decisions. Responded to initially by EDT out of hours. Responded to next working day (9th) through Safeguarding Duty screening; initial information gathering. Proportionate to progress through assessed care and support in first instance through ASC Hospital Discharge Process. TICAT involvement with Patricia and Christine. Outcome, discharge home, all care to be provided by family and declined ASC input.

SaTH on the 16th Patricia was admitted until the 17th following a **GP** referral. On this admission it was noted that Patricia was not happy with being admitted and wished to go home. On the admission documentation it was noted that she lived with her daughter and her daughter's husband and that carers came in daily. Again, she was seen and reviewed by the Occupational Therapy team and a further **DN** referral was made to **SCHT** for catheter care. Records indicated that her carers were daughter and daughter's husband with daily care support. **WMAS** transported Patricia to ED. On transferring Patricia to the stretcher, she sustained a skin tear to her left elbow. Wound care was given, and the correct incident reporting was completed. The crew also completed a safeguarding referral as they were concerned that she had unmet care and support needs. The crew had to request a bariatric vehicle in order to transport her to hospital.

ASC on the 16th a safeguarding contact from **WMAS** regarding a concern that needs were not being met; also, due to weight safe exit from property in emergency would be compromised. *"She is bed bound and morbidly obese and needs a lot of assistance and her daughter cares for her. Crew do not believe her needs are being met. There is no way of getting this lady out of the property in haste as she is that big. Care and OT assessment required. The daughter does not understand how serious it could be if her mother had to be removed quickly in the event of an emergency."* Conveyed to ED therefore, contact generated to Health & Social Care Rapid Response Team (HSCRRT) for follow up. HSCRRT follow up, case notifications, Patricia has returned home and declined all care at this time. Duty SW has confirmed refusal of support, and the contact was closed.

SCHT on the 19th a phone call was received from Christine to advise that Patricia has been fitted with a long-term catheter whilst in hospital which will require changing in 12 weeks' time. Appointment planned for beginning of January 2024.

GP on the 27th a home visit requested by Christine for Patricia. GP discussed with Christine and a visit arranged for early afternoon with a clinician. This visit occurred

whilst Christine was present. Noted Patricia bedbound, obesity, cared for by daughter with no outside care package, Patricia not wanting hospital, wants to stay at home/not be admitted. Antibiotics and steroids were issued by GP and safety netting done with regards to calling 999 if becoming more unwell.

SCHT on the 29th a DN visited Patrcia's home due to her catheter rubbing on the side of Patrcia's leg causing redness. Strap fitted to catheter.

GP on the 31st notification of an out of hours consultation. Clinicians had spoken to Christine who was trying to get the catheter removed (was inserted during hospital admission).

5.5 November 2023

SCHT on the 6th a DN visited Patricia over concerns of a blocked catheter. It was ascertained that additional catheter bags were needed. Additional supplies ordered.

Patrcia continued to receive care from the DN team regarding catheter care and DN's had been re-catheterising on a weekly basis due to concerns around the catheter blocking frequently despite PH testing, and saline washouts.

SaTH on the 11th Patricia again attended ED via **WMAS** with a blocked urinary catheter, again a bariatric ambulance was required. On this occasion there were no safeguarding concerns identified. Patricia was noted to live with her family. Following catheterisation, she was discharged home from the department. A further update was referred through to the community teams for catheter care. Family was contacted prior to transport home.

GP on the 25th an out of hours (OOH) consultation with a blocked catheter. Patricia unable to pass urine all day, rapid response and DN team had no capacity to see. OOH GP saw at home, flushed catheter and issued antibiotic and thrush treatment.

5.6 December 2023

GP on the 5th telephone consultation with Patricia, UTI symptoms treated with antibiotics.

GP on the 9th an out of hours appointment with the GP who re-catheterised Patricia due to a blocked catheter.

GP on the 14th DN email practice regarding recurrent catheter blockage. DN spoke to continence team who advised open ended catheter and bladder washouts. Prescriptions were issued.

5.7 January 2024

GP on the 1st an out of hours visit the GP re-catheterised Patricia as DN had removed previous catheter and could not reinsert new one.

GP on the 12th out of hours visit for symptoms of UTI and pain in the vaginal area from catheter. Also, joint pains chronic, paracetamol and tramadol not helping. Seen with Christine, diagnosed with a UTI. Unable to fully examine due to body habitus/ reduced hip movements. Issued antibiotics and oral morphine for pain relief.

GP on the 16th home visit by a clinician for foot cellulitis. No fever, not unwell. Was already on broad spectrum antibiotics from 12th so advised to complete these. Swabs were taken. Patrica complained of widespread pain, so follow-up call arranged with usual GP for the next day.

GP on the 23rd a telephone consultation with Christine regarding ongoing leg pain and weeping. Referral made to DN team to review.

SaTH on the 29th a discussion took place with Christine around Patrcia having a *'ancestry visa'* and what this allows for care. Christine confirmed that they were declined care funding 12 months ago and she would not consent to another referral today due to the stress it causes the family and creates a feeling of burden by the patient. The notes indicate that the family cannot afford private care.

5.8 February 2024

GP on the 1st a telephone call between clinician and Christine. Patricia not eating, urinary symptoms, some confusion. Home visit arranged and diagnosed UTI with oral thrush.

GP on the 3rd seen by GP as rapid response had no capacity to visit. Christine was at work, son-in law was outside the house because he was about to leave. History obtained from son-in-law and Patricia was seen alone by the GP. Christine arrived towards end of visit. GP found Patricia to be peri-arrest, very unwell, was hypothermic despite having electric blanket on top of her. GP called 999 and ambulance attend. An urgent back up with the bariatric ambulance was requested and Patricia was extricated utilising 2 frontline crews as well as a community first responder and the operational manager. Once safely removed from the property, she was transported under emergency conditions to Princess Royal Hospital with a pre-alert placed. It is important to note that due to her weight noted as almost 30 stone the crews encountered some challenges with the extrication from the property to the ED, especially in the final attendance, which made these transfers protracted and complex. Specialist equipment was required in order to keep both Patricia and clinicians safe.

SaTH Patricia was subsequently admitted for her final care period and died on the 14th. During this period of care safeguarding concerns in respect of self-neglect and possible neglect were identified and referred through to the Local Authority which

ASC receive on the 6th. Referral responded to however due to sad death of Patricia opportunity to further progress did not arise.

6. Practitioners Event

6.1.A practitioner learning event was held in June 2025. This event involved front line staff and was facilitated by the report author. The purpose of the practitioner event was to provide professionals who had worked with Patricia and knew her in that context, to share their insights and identify key areas for learning. The author would like to thank all members that participated for their open and honest approach to learning and understanding that, though distressing, this event was key to shaping learning and not blaming any individual or agency.

6.1.2 Participants/professionals were asked to consider the circumstances of Patricia's death with reference to:

- What went well?
- What could have been done differently?
- How to improve learning?

6.1.3 Challenges that were identified for Patricia we're in the main challenges that involving her ancestry visa status. It is very clear from the professionals involved that this was a barrier for Patricia for further support as the family did not have the funds available for a care package.

6.1.4 During discussions participants identified it would be beneficial if more information was known about what support is given to those in this country on an ancestry visa, including within the health and care spaces. The practitioners raised the question that when a person receives an ancestry visa is it clear at that stage what exactly you are entitled to. They also questioned is it discussed at this stage that as situations change in your life what that entitlement would be should you need specific forms of care and support. NB. From open-source research it is really difficult to understand what you are entitled to and the question asked by practitioners seems valuable.

The Home Office to consider a review of information that is available to health and care professionals and families when applying for and being granted an ancestry visa.

6.1.5 It was very clear to all practitioners involved that Christine was trying her best in difficult circumstances to care for her mum whilst also working and managing a wider family. However, Christine and the family were adamant and consistent throughout that they did not want other care for Patricia, and they would provide the care. What was also apparent was the dietary habits of Patricia. This would not be considered a healthy diet especially when you are fitted with a catheter and her underlying health challenges.

7. Analysis and Learning

7.1 Having reviewed the chronologies, and agency reports and listened to the practitioners involved in caring for Patricia an analysis for each of the key lines of enquiry identified is outlined below.

7.2 Patricia's care was predominantly provided by her daughter Christine.

7.2.1 Was a carers assessment considered and undertaken?

There are no referrals to specialist carer services. Throughout the review it is clear that Christine discusses that she is happy to care for her mother and that her own work can fit around her returning home to her mother.

7.2.2 Had Christine appropriate training in safe ways to move her mum, care for her skin wounds?

SaTH made enquiries with both Patricia and Christine during admission as to how they managed at home and equipment needs. The Trust does not routinely provide training for carers but can and does make arrangements where necessary. Referrals to the District Nursing services were made for catheter care and skin care.

SCHT records support conversations were held between DN's and Christine regarding Patricia's care needs and agreed to an Integrated Community Services (ICS) referral, which may help support Christine to care for Patricia more safely. It was identified that an equipment and a moving and handling assessment would be helpful to identify any further care needs for Patricia.

What is clear from records is that discussions were held with Christine in respect of discharge planning on each occasion. What was very clear from the review is the family wish for Patricia to return home, that they would provide all support and that Patricia was in agreement and had capacity for this decision. However, there is no evidence presented to the review in relation to training for moving and handling, skin integrity or wound care. It is not apparent from records that there is discussion with Christine regarding any potential risks that could arise from the family undertaking care without additional support or their understanding of this. There is a lack of detail to indicate that there is a discussion regarding how Christine would manage the care needs or escalate any health concerns should her mother's condition deteriorate. It is clear moving and handling needs were likely to be significant in view of information on the record regarding weight and the number of people required to move/transport Patricia (2 ambulances, at one point 5 persons in hospital to move/turn).

There is no known information as part of this review that respite was considered as an option for Christine.

7.2.4 Were their other pressures Christine was under alongside her role as carer?

Notes support that Christine did not fully accept she was struggling to care for Patricia adequately. It was not identified in notes that the DN's contacted Family

Connect to request or seek any further support for Christine. Christine also had a job and also grandchildren.

7.2.5 Was anyone else involved in Patricia's care (to assist Christine)

Notes indicate that Christine had *'some support from her husband'*. ASC have identified that outside the scope of the timeframe requested for this review, it is noted on previous episode of engagement with ASC, case note 18/6/21 that Christine had requested for Patricia to be discharged home to be supported by Christine and her sister who are *"trained carers".* Again in 17/10/23 from notes that Christine informed ASC a hospital bed was in place and she and her sister are her Mum's main carers. There is evidence within MPFT records that Patricia's husband and sister were supportive in caring for Patricia and supporting Christine.

7.3 Did Patricia's immigration status have an impact in her decision making with regards to care?

7.3.1 Within SaTH Immigration status is routinely explored for patients being admitted into Trust care who are not British nationals. It does not affect care nor prevent care being provided. Christine did inform ward staff that she had tried to get funding for help as a registered carer but was not entitled to any as she was from South Africa. Christine informed that they had no health/medical insurance. The family had initially led staff to understand that Patricia was in the UK visiting family and not a long-term resident. It was later identified that Patricia had moved to live with Christine in 2016.

7.3.2 From SCHT records Patricia voiced concerns to SCHT staff regarding if she would be eligible with funding for care, due to Patricia and Christine having an ancestry visa and originating from South Africa.

7.3.3 From GP records when Patricia originally moved to the UK she was registered at another practice and the new practice didn't have any notes, so the registered GP had to get a lot of background from Patricia. At a previous GP surgery, a social prescriber discussed the care situation in November 2021. Christine said due to visa's, Patricia wasn't eligible for funding for carers & the family couldn't afford to pay for private carers.

7.3.4 From ASC records outside of the relevant time period of this review a case note on 30/6/21 Christine mentioned that Patrcia did not have legal status in the UK. Christine stated she was in the process of doing it. Christine was told, if that was the case, Patricia was not entitled to public funds. At the time the case was in process of transfer to Stafford in relation to any ongoing considerations for Care and Support. Also, it is referenced on that referral information on the Safeguarding Contact that: "*patient originally from south Africa and over here visiting family. Will be self-funding."*

7.3.5 Records indicate that discussions occurred between TICAT and Christine regarding discharge planning in respect of the admission dated 7/10/23. Ordinarily this would include a discussion in relation to financial assessment where care is assessed as eligible/required and formulated. Such a discussion may also explore if Enablement Funding is indicated or if there is a requirement for Decision Support

Tool for consideration of Continuous healthcare funding. This is not indicated as explored from recording on the record; however, this is balanced against being briefly indicated as self-funding and no formal care package implemented due to Patrcia/family expressed a wish to return home with support provided by the family.

7.3.6 Christine declined to share details of Patricia's immigration status as part of a financial assessment, however also told the social worker she would be cancelling care as she was making other arrangements. It is unknown the reasons for Christine not sharing Patricia's documentation, however she told the financial assessor this was as documents were in her sister's attic and her sister was having building work completed.

7.3.7 MPFT records indicate that Christine was insistent at times that she would not be eligible for funding, however this was professionally challenged by both district nurses and social workers. Care was never refused to Patricia on the basis of her not having recourse to public funds.

7.4 Was the manner of her death predictable?

7.4.1 From SaTH on her last admission Patricia was admitted with a high NEWS score (high risk of clinical deterioration), this was indicative of Sepsis. She was diagnosed and treated for Urosepsis. It was identified at that time that due to her very poorly condition that if she did not improve with full active treatment within the following 24 hours that End-of-Life care would be the appropriate pathway. Patricia continued to deteriorate despite IV antibiotics, oxygen therapy and fluids and Patricia moved onto End-of-Life care on 07.02.2024. Patricia's death was expected.

7.4.2 The GP IMR has stated that Patricia had been having recurrent urine infections and catheter problems. In hindsight potentially she should have been on prophylactic antibiotics.

7.5 Were the signs of self-neglect recognised by all staff and what action had been taken?

7.5.1 Working with self-neglect is widely recognised as a complex and challenging area for practitioners. The second national analysis between April 2019 and March 2023 of SARs in England[3] highlighted that self-neglect was again the most common factor of abuse or neglect that had led to the SAR being held, accounting for 60% of all reviews, a rise from 45% from the first national review.

7.5.2 Making Safeguarding Personal (MSP)[4] recognises individuals' rights to self-determination on the understanding they have capacity to make key and critical decisions. Safeguarding interventions need to be person centred and involve the adult, working towards agreed outcomes. Safeguarding individuals can be challenging where agencies have struggled to effectively engage with the adult Duty of care means taking all reasonable and proportionate steps to manage presenting risks, including non-engagement. This is reiterated in policy: 'Making Safeguarding

[3] Second national analysis of safeguarding adult reviews, Final report: Stage 1 analysis
[4] Making Safeguarding Personal | Local Government Association

Personal'. It does not mean 'walking away' if a person declines safeguarding support and/or a S42 enquiry. That is not the end of the matter. Autonomy and self-directed support must be balanced with risk, the duties under the Care Act and the principles of the Human Rights Act.

7.5.3 SaTH Emergency Department Staff completed a safeguarding referral in respect of self-neglect/possible neglect on 07.10.2023 during an admission period of 07.10.2023 to 13.10.2023. However, a concern was not raised in February 2024 when she attended ED again, but a further concern was raised in respect of self-neglect following transfer from ED to the ward on 06.02.2024.

7.5.3 SCTH concerns around Christine looking after Patricia on her own were discussed. Patricias personal hygiene and that her ancestry visa did not allow for funded care. A referral was made to ICS for additional support. Signs of self-neglect were not recognised by all staff regarding Patricia.

7.5.4 The first presentation to Adult Safeguarding occurs in October 23. In respect of alleged Self Neglect, it is proportionate to explore through all standard interventions for support/care in the first instance. There is evidence of partnership work between Safeguarding and Hospital Teams to address her presenting needs. Patrcia's voice is heard with the family also involved as advocate. Their outcomes are expressed, and a common theme is their wish to be at home with care provided by family. It is accepted in discussions in respect of discharge planning that the daughter will provide all care. The record offers limited information as to how the family intend to achieve this, other than it is suggested that it will be done with assistance of one other (Christine's sister).

7.5.5 Self neglect was not evident during Patricia's care with MPFT. Patricia initially worked with therapists to regain mobility however was unable to due to pain/ oedema in legs. Patricia allowed District Nurses to monitor pressure areas and wounds, Patricia allowed care packages from Home First and Edith Care. The state of the property was raised by the ambulance crew in 2021 however neither therapists, nurses, social worker, Home First or Edith Care raised this as an issue when delivering services.

7.6 What is the process when skin wounds are not improving when managed at home?

7.6.1 SCTH have confirmed that skin wounds would be reviewed and considered for any additional specialist service overview (such as Tissue Viability) and any additional pressure relieving equipment that may be needed. If not improving, then this may need additional intervention in an acute hospital setting. Tissue Viability Nurses follow the National Wound Care Strategy Programme Pressure Ulcer Clinical Pathway.

8 Conclusions & Good Practice Identified

8.1 During the first period of admission in October 2023 it was identified within the care notes that up to 5 staff were required to turn Patricia, however she was

discharged into the care of her daughter, who declined additional care. Further professional curiosity as to how exactly Christine and Patricia were managing at home might have been further explored at this point. Whilst it is noted agencies are already working hard in this area notably:

Shropcom - Professional curiosity - briefing/media produced to encourage to be threaded through. Involved with other reviews taking place.
SATH - changed programme training in April. Featured in newsletters. Face to face training - case scenarios delivered.
ASC - feature within newsletter.

The panel have agreed the recommendation in this area.

Recommendation 1. All agencies to place a greater emphasis on professional curiosity. To revise the current face to face training programme updated training package to raise awareness about the value of exploring home circumstances/relationships further.

8.2 SCHT has already implemented learning as a result of their own review being:

- Records should be clear about whether or not a referral to social care has been made. This learning has been shared with the District Nursing Team.
- Raise awareness around professional curiosity. A permission to pause to with a focus on professional curiosity 5 minute video was produced and appropriately shared.
- Raise awareness on importance of record keeping and recording when a safeguarding referral/request for care assessment has been made. Has been appropriately shared.

SCHT as did this review identified the need for Multi-Disciplinary Team working was not discussed or identified. The DN team had opportunity to request wider discussion with relevant professionals and engage them in a MDT approach to identify any further actions or approaches that could assist in the care of Patricia and support for Christine. Whilst it is noted MDTs are held daily within SATH and do not always require safeguarding. Also, within ASC, some multi agency /strategy discussions had been held. Shropcom encourage use of MDT forms for recording but not always used. It was difficult to tell from notes whether MDT has taken place.

Recommendation 2. All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.

Recommendation 3. All agencies to ensure staff have easy access to information and assessment tools (such as self-neglect toolkit) this is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them

maintain their professional knowledge and understanding of complex safeguarding issues and where to go to get the help.

8.3 From the GP records it is apparent from the notes that it was known that Patricia was cared for by her daughter and had no formal outside care agency involvement. It isn't documented whether Christine was directly asked about whether she was equipped / capable of caring for her mum, or whether she knew how to care for pressure sores/wounds. There is mention in a letter that daughter Christine had a separate job as a carer, so if this was mentioned to clinicians, one hypothesis was perhaps it was presumed that Christine was capable of caring for her mother.

8.4 The GP practice felt that there is a presumption in primary care that when a patient is discharged from hospital, social workers are involved in discharge planning if there are any concerns about care / neglect. Again, another hypothesis perhaps this is why clinicians didn't question pressure areas/ skin care / carers assessments?

As a result of this review the GP practice has already implemented:

- A presentation to all clinicians of the case of Patricia.
- A process for searches for housebound patients with obesity performed by the safeguarding coordinator every month to identify at risk patients. Then discuss care needs / wound issues with patients found by the search.
- The case of Patricia has been discussed and shared with clinicians in the surgery as part of a clinical meeting. The emphasis was on the impact of severe obesity on health, and the need to directly question how patients are washing/dressing/ having skin care etc

8.5 As with other agencies, within ASC more professional curiosity at the point of discharge could have assisted, in particular how realistic the family view is, or if this is an over estimation of their ability to meet Patricia's needs. It would have been beneficial if ASC recording demonstrated the extent of discussions around the reality of this arrangement, in view of her significant care needs and potential risks as detailed earlier in this report.

8.6 WMAS are an emergency service, and their primary focus is often on responding swiftly to patients in urgent need and in all attendances, there was clinical need to rapidly transport to ED. However, this rapid response environment can sometimes result in missed opportunities for deeper professional curiosity, particularly when the nature of the emergency is highly acute and requires immediate intervention.

8.7 Within the time frame of the review WMAS responded 4 times however only raised a safeguarding referral on one occasion (16.10.23). It has been considered whether there were opportunities to make a safeguarding referral on the 3 other occasions accepting the role described at 8.6. However, to address these challenges and continually improve practice WMAS have:

- Provide Annual Training Updates: To ensure clinicians receive regular training and updates on professional curiosity, with a focus on identifying potential safeguarding and domestic abuse concerns even in high-

pressure situations. They recognise the importance of embedding professional curiosity more deeply into routine practice.

- Promote Awareness: Training includes scenarios and guidance on how to balance immediate care needs with safeguarding responsibilities, helping clinicians recognise and act on subtle cues that might indicate underlying issues.

- In cases of self-neglect, they are committed to adopting a collaborative and supportive approach. This includes:
- Recognising the signs of self-neglect and understanding its impact on the individual's safety and quality of life.
- Working closely with partner agencies to create tailored care plans that address immediate risks while supporting long-term well-being.

- WMAS has recirculated information to staff around professional curiosity and will recirculate information to staff around self-neglect.

8.8 Within SCHT Continual regular reviews and District Nurse face to face visits for catheter input are evident from the electronic patient record. Appropriate interventions and advice is given to Patricia regarding catheter care and exploration of alternative measures (Washouts, PH testing). There is appropriate identification of additional care needs regarding care act needs assessment requirements, however not clear from records that these were raised further.

8.9 There are multiple instances of good practice within MPFT's interventions. DN have good communications with GPs and made multiple referrals to other services for support both within and external from MPFT. DN identified Patricia had not had her 2nd Covid vaccine or flu vaccine and chased these.

8.10 What has been very clear to the review is that Christine and the family were adamant and consistent throughout that they did not want other care for Patricia, and they would provide the care and wished for Patrcia to return home.

9 Recommendations

Recommendation 1. All agencies to place a greater emphasis on professional curiosity. To revise the current face to face training programme updated training package to raise awareness about the value of exploring home circumstances/relationships further.

Recommendation 2. All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.

Recommendation 3. All agencies to ensure staff have easy access to information and assessment tools (such as self-neglect toolkit) this is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them maintain their professional knowledge and understanding of complex safeguarding issues and where to go to get the help.

Recommendation 4. The Home Office to consider a review of information that is available to health and care professionals and families when applying for and being granted an ancestry visa. (The panel also recommended an easy read version).