Safeguarding Adults Review- Learning Summary report

‘Roy’*

Date: August 2025

*Pseudonym

What is a Safeguarding Adults Review? (SAR)

A Safeguarding Adult Board, as part of its s.44 Care Act 2014[1] statutory duty, is required to commission SARs under the following circumstances:

'***(1)*** 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 safeguarding the adult, **And**

(b) condition 1 **or** 2 is met (see below)

(2) 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)

(3) Condition 2 is met if: -

(a) the adult is still alive, **and (b)** the SAB knows or suspects that the adult has experienced serious abuse or neglect

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.'

[1] Care Act 2014

About the Review Process

The purpose of the Safeguarding Adults Review is to identify the lessons to be learned from analysing the way in which practitioners and agencies worked together and separately, to safeguard the person. To maintain confidentiality and in respect of the family wishes for the purpose of this review, the person and their family have been anonymised and therefore pseudonyms will be used, the person subject to the review will be referred to as 'Roy', his wife 'Janet' and daughter 'Sophie' throughout.

The scope of the review covers a period of time where the whole country faced a great deal of uncertainty due to the unprecedented restrictions in place as a result of being in the midst of the Covid-19 pandemic. The review has looked to explore the impact of the pandemic and the impact on Roy and his family, and all the professionals working during this period.

During this period Roy was reported to have mobility issues and relied heavily on his wife and children for his care needs. Due to the heavy restrictions imposed at the time, to professionals having to adhere to lockdown restrictions and the national reporting around the pandemic, there was a great deal of fear felt by vulnerable adults.

The majority of health and social care provisions were offered via virtual means and home visits were somewhat reduced, due to the uncertainty this often-left vulnerable people wary of allowing anyone into their homes. The review will seek to identify good practice on the part of those professionals. Where there were challenges, the review will seek to identify the systemic, cultural or organisational issues that contributed to any failings to enable any learning to be taken away and review to what extent subsequent changes have addressed those identified issues, and what more needs to be done.

A Multi Agency Approach

A Safeguarding Adults Review (SAR) has been undertaken by the Surrey Safeguarding Adults Board (SSAB) in conjunction with both statutory and third sector partners who work across the Surrey footprint, in respect of an adult known as 'Roy'.

A Multi Agency learning event chaired by one of the statutory partners and well attended by the partner agencies was undertaken to focus on key leaning points which have been identified by agencies working with Roy and his family at the time. The discussion led by the partnership, looked to explore and unpick the learning points, identifying key practice episodes, identifying areas of improvement and good practice examples.

Following the multi-agency discussions and the analysis of the information provided by all agencies involved, a Learning summary report has been produced to summarise the key findings taken from the review, this is to support the facilitation of the learning, including good practice examples being shared with all professionals working across the Surrey footprint. These include members of the Safeguarding Adults Board, partner agencies and frontline practitioners.

Please take time to review the findings, reflect on practice and encourage ways to learn, develop and work together. Summary reports are there to help identify clear learning points to improve outcomes, to prevent harm occurring and to support Adults that have a need for care and support.

Areas for consideration- The review asked agencies to focus on the following areas:

1. **Cause of death- bronchial Pneumonia**

- How does this link into Roy's death (did he have it for a long time?)

2. **Impact of COVID**
   - Family did not want anyone to visit the home due to covid (early days, people did not know how to react).
   - ASC delayed visits June until Aug 2020.
   - Lack of professional curiosity.
   - Carers assessment.

3. **Use of language within enquiries**
   - Palliative care.

4. **MCA and the decision making of next of kin**
   - Mental Capacity Act – Best Interest decisions, who is the decision maker?
   - End of life care - 'having a good death'.

The section 42[1]. safeguarding enquiry that concluded after Roy's death found that-

- 'It appeared that Roy did not get the palliative care that it was intended he should have had'.
- 'Information about the risks he faced was either not shared, not well understood, or not acted on, which resulted in the incorrect priority being given by Adult Social Care to the referral received on 19/06/2020 which meant he was not seen by Adult Social Care until 06/08/2020.
- 'Health and social care agencies relied on information provided by Janet which did not give an accurate indication of the level of risk to Roy'.

Roy's Story

Roy died in August 2020 of Bronchopneumonia at the age of 73 years old. The coroner's conclusion stated that 'although Roy had other significant conditions which may have contributed to his death, these were not directly linked'.

Roy's health was noted to have started to decline early in 2018 following his return from living abroad. He had been living with a diagnosis of Dementia since early 2019 when he became known to services in Surrey following reports that he had experienced several falls, which had increased his vulnerability. Although Roy had poor mobility, there was a feeling amongst professionals that he previously had been a private person, who had been fiercely independent and would be somewhat frustrated having to rely on his wife and family for his care. Practitioners felt that this may have impacted on Roy's wish to have limited external support.

Roy lived in a mobile home with his wife, and they had an adult daughter who lived locally. It is believed his home environment may have posed some challenges to someone with mobility issues, which may have impacted on the resources available to both Roy and his wife, restricting the support available due to the limited space.

Roy was reported to have expressed his wishes on several occasions prior to becoming unwell, that he would like to stay at home towards the end of his life and did not wish to die anywhere else. Roy's wife Janet and daughter Sophie had supported his wishes and when he was no longer able to communicate such wishes, Janet continued advocating on his behalf throughout. Janet expressed worry about leaving their home as at the time the reported risks in relation to Covid-19 caused undue stress to vulnerable people.

Taken from the Sect. 42 Safeguarding enquiry:
Janet tried to care for her husband herself the best she could according to her account, and she was embarrassed to have external care and support involved due to Roy's aggressive

[1] Care Act 2014

behaviour at times. Janet expressed a view that she wanted her husband to feel comfortable and that he would have wanted to be cared for at home. When paramedics were called, Janel and her daughter stated that Roy is dying, and family want him to pass away at home.

Overview of the Case

A referral for a Safeguarding Adults Review (SAR) was received in October 2022 in relation to Roy who had died 2 years prior in August 2020.

Roy was reported to have experienced episodes of confusion and aggression at times, in addition to poor mobility. Due to this at the time of his death he had been cared for in bed by his wife Janet with some support off their daughter Sophie.

It is important to reiterate the fact that Roy's health declined significantly at the beginning of the Covid-19 pandemic just as the whole country went into a lockdown, which was a first of its kind and there would have been significant unprecedented pressures and demands on all agencies, as well as uncertainty for the family. It is also pertinent to include that at the time, media reports were often overwhelming and scary for vulnerable people due to the daily reporting around the number of deaths, particularly around elderly vulnerable people. Agencies often reported that some elderly people were reluctant to engage in any care provisions, including home visits due to their worries around the spread of Covid-19.

Although by the time Roy's health had further and rapidly declined, the lock down restrictions had been lifted somewhat, there would still have been a significant level of anxiety for both Roy and his wife around meeting with external people.
Throughout this period Roy's wife Janet continued to care for Roy within their home, which would have likely caused her significant pressure and carer fatigue. There is little evidence to suggest that Janet was offered any carers support, although on one occasion she was offered a carers assessment, this was declined without any further sensitive conversations to ascertain the need for any support that would have been needed and due to the pandemic, it is highly likely that his would have been declined.

Family

The Safeguarding board and partners would like to extend their condolences to the family and friends of Roy.

Due to the passage of time since Roy's death, the partnership has agreed that it would be in the family's best interest not to make direct contact with them, as this may cause more distress and likely to retraumatise them. With this in mind the learning from this review incorporates both Roy and his families wishes given to agencies at the time he was engaged with them.

Agencies Involved with the Review

*Surrey Heartlands ICB	Helen Milton (chair)
Surrey County Council, Adult Social Care	George Kouridis
SECAmb	Philip Tremewan
CSH Surrey	Gurpreet Brar Nadine Hammond
Ashford & St Peters Hospital	Jane Mitchell
SABP	Neil Thompson
GP Surgery	Dr Sundeep Soin Faye Harvey
*Surrey Safeguarding Adults Board	Jolene Llewellyn

*Agencies coordinating the review

Learning Themes

The Impact of the Covid- 19 pandemic and subsequent restrictions

The covid-19 pandemic and the subsequent restrictions in place resulted in many vulnerable people being isolated and worried about the implications of accessing services, it is clear that prior to becoming unwell Roy had been a fiercely independent man, who tended not to access services unless necessary. Due to the restrictions, many agencies defaulted to offering arms reach services, however Janet who had become the advocate for Roy when his health declined continued to support his wishes and requested little support.

Multi-Agency Working, Co-ordination, Information Sharing and use of language- The Interaction Between services

It is clear from the multi-agency discussion and the information provided that there appeared to be multiple agencies involved in engaging Roy during the scoping period of time discussed, although it is unclear how many of those agencies were working with Roy at any one time and as there did not appear to be a clear lead agency coordinating a multi-agency plan around the support that should have been offered to Roy there were missed opportunities.

Information sharing including detailed recording across agencies appeared to be poor and at times did not capture the clear risks faced by Roy which could have been escalated. This resulted in an over reliance on Janet as the sole carer to provide information, without any checks or oversight undertaken. This may have been as a result of the use of telephone contacts, rather than home visits due to the covid-19 restrictions.

When assessing Roy, there appeared to be a concern that incorrect priority was given to allocation of a worker, with the risks posed to him being minimised. This may be due to the language used when Roy was recorded as someone on a 'palliative care pathway', when there was no referral made to the Palliative care team. This confusion would have delayed support offered.

There is a clear learning point around language, especially when talking about 'palliative care' versus 'end of life care'. With Roy it was clear that both the family and visiting practitioners were aware of his level of deterioration his death would be imminent, however it is unclear whether the family were assured that medical attendance was to make Roy comfortable or to transport him to hospital, which was not his wishes.

Dementia Awareness

It is unclear whether Roy or Janet had received any further advice and guidance in relation to his dementia diagnosis. Although this is something that they may have declined, there does not appear to be any further discussions around this. Although the coroner did not attribute this diagnosis to his death, this could have been a contributing factor to his deterioration.

Working with family members with caring responsibilities

Janet clearly vocalised concerns around the risks of agencies entering their home during the pandemic, including feeling embarrassed at needing external care for her husband, who she reported at times could be aggressive. However, it does not appear that further discussions, assessments or offer of support was made to Janet who would have been the main carer. Roy's voice does not appear to be present in any agencies assessments and there was an over reliance on Janet to make decisions on behalf of Roy, although It is clear that Janet and Sophie wanted to advocate Roy's previous wishes to stay at home.

Two months prior to Roy's death, he had become bedbound, sleeping for longer periods and Janet had reported to health colleagues that she felt that he had deteriorated significantly was dying. Although this disclosure happened within a face-to-face home visit, this wasn't explored further, and no referral was made to palliative care. This is a real missed opportunity where open and honest conversations around wishes could have been acknowledged and recorded.

Communication around the use of the respect form, empowering staff to have open conversations with families to use this to support families around their wishes.

Engagement with those that wish to not be engaged.

Throughout Roy's story, there appeared to be several missed opportunities to have multi agency discussions in relation to the decisions around engagement. Understanding that this was a period where engagement may have been difficult due to the pandemic, there appears to be little exploration into different approaches in engaging Roy or his family.

Concerns were raised by Roy's daughter Sophie around the lack of a package of care; however, it was felt that Roy and his wife had declined this, unfortunately there doesn't not appear to be any 'professional curiosity' or discussions held with the family as to why.

This should link to the recommendations around having early conversations with families around their wishes and feelings, this may have helped understand the resistance to engagement.

The Assessment of Mental Capacity and Best Interests Decisions.

There appears to be several missed opportunities to ascertain Roy's capacitive decision making in relation to best interests decisions.

When a visit had taken place in early June, Janet was spoken to around her role as carer for Roy, where she was reported to have declined a carers assessment due to her concerns that Roy would become aggressive with carers, Roy wasn't spoken to. A week later Roy was spoken to, and he gave verbal consent for a referral to be made for a carers assessment, however at no point was a mental capacity assessment completed. At the same time Janet was observed as looking very tired and mentioned she had hurt her back whilst moving Roy, this was not explored any further.

Autonomy and Safeguarding.

During the multi-agency discussion, it was acknowledged that there had been a generational shift in peoples autonomous decision making around their deaths, dying at home was a thing of the past, however, there appears to be a shift with more and more people now wishing to choose to die at home and it is recognised that this can happen now in a much more managed way.

One way that agencies can understand someone's wishes in relation to dying is to introduce earlier conversations around this. The ReSpect form is currently used to have these, sometimes difficult conversation, which is much more that the DNR element, if used appropriately it should give people and families the opportunity to highlight their wishes people's decisions and care planning including decisions for planning for end-of-life care.

There is a general thought that not many people are aware of how best to use this form, and we may wish to consider asking the question if we could ask for the form to be rebranded as an 'Advanced care plan' to aid better discussions.

Since this review Central surrey have since employed two palliative care nurses.

Proportionality

It was clear that Roy had been struggling for some time with his mobility and there had been evidence that he was unable to access outpatient appointments due to his risk level in relation to falls. Roy's capacity hadn't been assessed, however when taking a person-centred approach- if someone does have capacity or not wanting to engage with services how do we approach-there is a huge balance. We need to consider proportionality. Would it have been a proportionate approach against the persons wishes. Especially retrospective looking back- as at the time it was the right thing to do, giving the right for a person to live their life and have their wishes listened to.

Good Practice

There is clear evidence of numerous multiple disciplinary discussions happening in relation to Roy's care needs and agencies working together to provide services, during an unprecedented period of time during the Covid-19 pandemic.

One clear example of this was the use of the multi-agency clinic, which offered outreach services and resources to Roy within their own home.

Information on Roy's condition following a Community Matron visit was shared appropriately with Woking Locality Team, including clear managerial oversight as part of OT duty desk management and MDT meeting for Bedser Hub, where Roy's circumstances were also discussed.

Extending outside of the scope of this review, we would also like to acknowledge the good practice example which happened in October 2018 –

Roy had been a licenced gun holder, however following a home visit by health professionals and an assessment of Roy following a deterioration of his condition, the health practitioners raised a concern directly with the Police around his firearm licence and subsequently his gun licence was revoked immediately. This showed a timely reactive multi agency response to an escalated risk.

This has also highlighted a change in practice
If a person who is registered at a GP surgery is known to hold a firearms licence, they are coded on the system and if they receive a diagnosis of anything such as dementia, they will automatically be flagged.

Recommendations for Agencies to Consider

Surrey Safeguarding Adults Board should seek assurance:

Recommendation 1:
All Agencies need to consider including a pandemics response- into their agencies Business continuity plan. Providing assurance to the Safeguarding Adults Board.

Recommendation 2:
All Agencies need to consider conducting multi-agency meetings and make use of the tool kit to assess risk and co-produce risk management plans in a proportionate manner to best support the vulnerable adult. Especially if they wish to remain in their own home.

Recommendation 3:
The Surrey Safeguarding Adults Board to co-produce awareness raising session/webinar around the use of the **ReSpect** form - encouraging positive conversations around future care planning, being more professionally curious especially around the end-of-life care and in relation to those living in the community.

Recommendation 4:
Surrey Adult Social Care (ASC) needs to provide assurance to the Surrey Safeguarding Adults Board (SSAB) that consideration is given that any carer is offered a timely S10 care act assessment.

Recommendation 5:
All agencies to consider the encouragement of all staff to access Dementia awareness training sessions and signing up their organisation to become a dementia friend.

Questions for Agencies to Consider

1) How do you support adults that are living with a Dementia diagnosis, making sure the wish of the person is heard.
2) When completing a mental health assessment of risk, are all factors considered?
3) Do you consider the engagement of family within care planning and when determining capacity?
4) How do you consider the home environment when assessing vulnerabilities?
5) Is there a need for further training and information to explore complex capacity assessments and how to support families to be supported to provide their views.
6) How can you support positive conversations around end-of-life planning to ensure the wishes of the person is recorded.
7) Is there a need for further training and information of the use of the RESPECT form.

   What support can your agency offer to help carers supporting family with care and support needs wishing to stay in their own home.

Links & Resources

The Mental Capacity Act 2005 Codes of Practice
https://www.gov.uk/government/publications/mental-capacity-act/

NICE Guidelines - Decision Making and Mental Capacity.
https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917 , 1.4.19

Respect Guidance
https://www.resus.org.uk/respect/respect-healthcare-professionals#:~:text=ReSPECT%20stands%20for%20Recommended%20Summary,to%20make%20or%20express%20choices.

Resources in Relation to Dementia

Heathy Surrey
Resources, guides and training | Healthy Surrey

Home - Dementia UK
Understanding and supporting a person with dementia | Alzheimer's Society

Surrey County Council, Adult Social Care - Safeguarding Adult
https://www.surreysab.org.uk/wp-content/uploads/2022/08/Adult-Social-Care-Levels-of-Need-V5-August-2022-.pdf

Please visit the Surrey Safeguarding Board for more resources
Homepage - Surrey Safeguarding Adults Board