



7 Minute Briefing

# SAFEGUARDING ADULTS REVIEW THEMATIC ACUTE HOSPITAL DISCHARGE

## THE ADULTS

This Safeguarding Adults Review examined a small number of cases involving:

- Adults aged 66–90
- All lived alone
- All with multiple long-term conditions
- All dependent on complex packages of care

Common factors included:

- Frailty and reduced mobility
- Pressure ulcer risk
- Declining or refusing care
- Safeguarding Concerns raised at various points

These were high risk discharges, requiring robust co-ordination across health, social care and commissioned home care providers.

## BACKGROUND TO THE REVIEW

The review focuses on acute hospital discharge back to the community for Lewisham residents with complex care and support needs.

It was commissioned following a small number of serious and concerning cases, where adults were discharged to their own homes from acute hospitals and later died.

The review does not determine cause of death. Its purpose is learning, improvement, and prevention.

Although the cases are few, they are considered sentinel events, highlighting system wide risks that may affect many more people.

The review also acknowledges the very high number of discharges from acute hospitals in Lewisham every year (c.10,000), the many pressures and challenges across all health and social care systems, and the good practice that was identified locally.

## WHAT HAPPENED

The cases that were reviewed involved Lewisham residents being discharged home from acute hospital (none were Mental Health patients) between 2023 and 2025.

All the adults were older people with multiple, complex health conditions. They lived alone and required significant health and social care support to remain safe at home.

In each case, the individual was discharged under established hospital discharge arrangements, using the Discharge to Assess / Home First model. Discharge planning involved multiple agencies, including acute hospitals, adult social care, community health services, and commissioned care providers.

Following discharge:

- Care packages were not always fully in place or stable.
- Equipment and pressure relieving resources were delayed or incomplete.
- Some individuals declined aspects of care, including personal care.

Risks increased quickly, particularly around skin integrity, self-neglect, and unmet care needs. Safeguarding Concerns were raised in several cases, but the review found inconsistency in how concerns were recognised, recorded, escalated, and followed through. Mental capacity assessments relating to discharge decisions and refusal of care were often unclear or absent, limiting effective risk management.

Over time, risks escalated rather than reduced. Despite contact with multiple services, there was no consistent multi-agency oversight of the whole picture of risk. All of the individuals later died, prompting concern about whether earlier opportunities to identify and manage risk had been missed.

The review does not conclude that discharge caused these deaths. Instead, it highlights how system weaknesses, gaps in professional curiosity, and fragmented decision making left highly vulnerable adults exposed to avoidable harm.

## KEY LEARNING

The Review found that the Discharge to Assess / Home First model was sometimes difficult to apply safely for adults with very high and complex needs. In some situations, returning home may not have been the safest option, and alternative arrangements were not always fully explored. While risks were often recognised, they were not always consistently reviewed, shared, or escalated across services.

Mental Capacity Act practice requires strengthening across the system. Capacity assessments related to discharge decisions, refusal of care and risk were sometimes unclear or incomplete, which made managing risk more challenging. There was limited evidence of supported decision making, best interest processes, or clear recognition of self-neglect where essential care was declined.

Discharge documentation and planning were not always complete. In some cases, care packages, equipment or pressure relieving resources were not fully in place when people returned home. These early gaps meant that risks could increase quickly once individuals were back in the community.

Approaches to the prevention, monitoring and escalation of pressure damage were variable. Where adults declined personal care, there were opportunities to strengthen professional curiosity and earlier escalation to better manage risk.

Although a “One Team” approach was intended, it was not always evident in practice. Records sometimes reflected different professional perspectives, and information sharing and shared ownership of risk were not always consistent or joined up.

Safeguarding Concerns were raised, but they were not always clearly identified, progressed, or concluded with clear outcomes. This meant that risk was sometimes managed informally rather than through a co-ordinated safeguarding response.

The Review identified the need for stronger, more inclusive governance arrangements for acute hospital discharge. Not all relevant partners are currently included in oversight structures, and there is no consistent multi-agency approach to reviewing high risk discharges, limiting opportunities for shared learning and assurance.



# KEY RECOMMENDATIONS

## Strengthen System Governance

Establish clear, system wide governance for acute hospital discharge, with full partner representation, shared oversight, and collective accountability for risk.

## Improve Mental Capacity Practice

Ensure Mental Capacity Act practice is lawful, consistent, and embedded across agencies, supported by coordinated training, audit, and assurance.

## Embed Safeguarding in Discharge Practice

Make safeguarding a core part of discharge planning, with consistent use of the Lewisham Adult Safeguarding Pathway and routine auditing of practice.

## Develop a Skilled and Curious Workforce

Deliver joint workforce development focused on mental capacity, refusal of care, pressure ulcer risk, professional curiosity, and escalation.

## Strengthen Learning, Review and Planning

Introduce regular multi-agency review of high risk discharges and use strategic needs assessment and commissioning to address system pressures and capacity gaps.

## QUESTIONS FOR YOU TO CONSIDER

If I'm worried about a discharge, do I clearly escalate it and know who is accountable for the risk?

Have I clearly assessed and recorded capacity where care is refused or risk is high?

Am I recognising when discharge risk becomes a Safeguarding Concern and acting on it?

Have I shared concerns and challenged decisions with partner agencies, or assumed others will?

How will I apply learning from this SAR in my everyday practice?

## WHAT YOU CAN DO TO PREVENT A REOCCURRENCE



This Review is a clear challenge to the system.

Safe discharge depends on:

- Strong Professional Curiosity
- Robust Mental Capacity Act Practice
- Shared Ownership of Risk
- Clear Safeguarding Pathways
- Joined Up Leadership

## LINKS TO FURTHER INFORMATION

- [Guidance on Improving our Approach to Adult Engagement March 2026](#)
- [Inter-Agency Escalation Policy \(July 2023\)](#)
- [London Multi-Agency Adult Safeguarding Policy & Procedures November 2025](#)
- [LSAB Self Neglect Policy, Practice Guidance and Procedures April 2025](#)
- [Pressure Ulcer Panel Process - In the Community Sept 2022](#)
- [Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK](#)
- [Guidance for Reporting Falls Events as Adult Safeguarding Concerns May 2024](#)
- [LSAB Professional Curiosity](#)
- [LSAB Mental Capacity, DoLS and Advocacy](#)
- [LSAB Learning Zone](#)
- [Lewisham Adult Safeguarding Pathway](#)
- [LSAB 7 Minute Briefing Professional Challenge](#)
- [Making Safeguarding Personal](#)



## LINKS TO RELEVANT LEGISLATION

- [Care Act 2014 – Section 44 Safeguarding Adults Reviews](#)
- [Section 42 Care Act 2014 - Enquiry by Local Authority](#)
- [Mental Capacity Act 2005](#)

