Safeguarding Adults Review: 'Sylvia'

1. Introduction

The primary purpose of a Safeguarding Adults Review is to draw out organisational learning about how the local agencies are working together, to support improvement.

This review concerns: **Sylvia**

- Sylvia was a 95-year-old woman. The coroner verified the cause of her death as:
  1. (a) Disease or condition leading directly to death - Cellulitis of the Left Leg
  2. Other significant conditions contributing to the death but not related to the disease or condition causing it - Frailty of Old Age, Atrial Fibrillation, Chronic Kidney Disease
- Factors investigated through the review are self-neglect and neglect and acts of omission.

2. Legal framework

Under section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care and Support Statutory Guidance states that SARs should seek to 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. Its purpose is not to hold any individual or organisation to account.

The PSAB SAR subgroup considered the case referral (made by South Central Ambulance Service) for Sylvia on 12 March 2025 and concluded that the above criteria for a mandatory SAR had been met. The recommendation to commission a SAR was approved by the PSAB Independent Chair on 24 April 2025.

3. Aims and objectives

a. Examine local protocols for interagency working.
b. Make recommendations for change.

4. Scope

The SAR covers the following timeframe: 1 January 2024 to 6 January 2025. Some contextual information from outside this period is also included.

The SAR addresses the following key questions:

- Were opportunities taken to safeguard Sylvia?
- Were Care Act duties fulfilled?
- How effectively did agencies work together to understand capacity, and risks such as falls, safety and self-neglect/ hoarding?
- How were concerns responded to about possible neglect / acts of omission by the domiciliary care agency?
- What practice issues are identified to ensure a more person centred and strength-based approach?
- Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

5. Agencies involved

- South Central Ambulance Service (SCAS)
- Portsmouth City Council (PCC) Adult Social Care
- Hampshire & Isle of Wight Healthcare NHS Foundation Trust (Legacy Solent NHS Trust)
- Hampshire & Isle of Wight Fire & Rescue Service
- Portsmouth Hospitals University NHS Trust
- Police - Hampshire & Isle of Wight Constabulary
- GP Surgery

6. Links to other reviews

Other PSAB SARs 'Mrs E' (2022), 'Mr F' (2022) and 'Anne' (2025) concerned the deaths of older adults in their own home. However, the circumstances of their deaths were very different from Sylvia.

There are, however, some general issues such as the importance of mental capacity assessments, Making Safeguarding Personal (MSP), hearing the person's voice, information sharing and coordination between agencies within a safeguarding framework and timely responses to concerns.

7. Methodology

- Review of scoping information detailing each agency's involvement with Sylvia.
- Contact with Sylvia's family.

- Consideration of the evidence, gaps in information and information and reflections from a workshop involving the key agencies.

There was a delay commencing the review while a Police investigation was ongoing. Work commenced in November 2025.

8. Independent author

The review was led by David Jones, who had no connection with any of the services involved at the time of Sylvia's death. The review was overseen by the PSAB's SAR subgroup.

9. Involvement of family members

Sylvia's daughter and son were contacted but responded that they did not wish to be involved in the SAR.

10. Background

Sylvia was a 95-year-old lady who was born in Portsmouth. Although she had moved away, she returned to the city in 1947 and met her husband who worked in the dockyard. They had two children.

Sylvia was frail and housebound with a complex medical history, including atrial fibrillation, osteoporosis, breast cancer and a tendency for recurrent falls. She was described as very chatty, friendly and had a wicked sense of humour. She was very independent but lonely, with limited family contact. She loved a cup of tea and natter.

Her health declined in her final months, and she became very frail and had lots of falls. It was noted Sylvia was a hoarder and as she struggled with her mobility, her house was neglected and described as squalid and cold.

11. Events prior to Sylvia's death

As her daughter and son reduced their involvement, Sylvia's main support came from a self-employed helper who provided practical help and companionship. Over her last six months, this support consisted of visits three times a week.

Sylvia's final year was marked by multiple hospital admissions, primarily following falls. A significant fall resulted in an open right distal tibial fracture in January 2024, requiring surgery. This led to a prolonged period of rehabilitation, first at Spinnaker Ward and then at home with a package of care.

Throughout the year, there were numerous contacts with GPs, nurses, the Acute Visiting Service (AVS), Portsmouth Rapid Response and Reablement Team (PRRT), Urgent Community Response (UCR), community nurses for wound care, occupational therapists, and physiotherapists.

From April 2024, a homecare agency provided support with daily living tasks four times a day.

There was some limited Adult Social Care involvement, including from the Adult Intermediate Care Team; there wasn't an allocated worker in the weeks leading to her death.

Sylvia had been in and out of hospital but was very independent and determined to remain living at home. She had mental capacity to make decisions although cognitive decline was observed.

The various agencies expressed concern about the increase in falls, her living conditions, and with the low temperatures in her home during the winter, the limited usage of a heater and the inadequacy of her clothing in these living conditions.

An ambulance was called out on the Sunday before she died and the crew reported that Sylvia was critically hypothermic. It was also reported that a tablet had dropped on the floor while one of the carers was giving Sylvia her medication, and they failed to notice this. The following day, another call was made when she appeared to have stopped breathing. The carers waited with her but did not contact 999 again. Upon arrival, the ambulance crew informed them that Sylvia had died.

A section 42 enquiry was undertaken, and the findings / recommendations were accepted by the homecare agency. Death through neglect was initially suspected but Police and Care Quality Commission enquiries did not substantiate this.

12. Findings

Were opportunities taken to safeguard Sylvia?

There was considerable contact from care and health agencies during the last year of Sylvia's life. The focus was on supporting her in the community and when in hospital, arranging early discharge.

It seems that this approach resulted in a lack of seeing risks through a safeguarding lens. One safeguarding concern was raised by the paid helper in September 2024 but none by the home care agency or community nursing. SCAS raised safeguarding concerns, but PCC did not respond and there were also delays in triaging. These were clearly missed opportunities to safeguard Sylvia.

The safeguarding concern was triaged but Sylvia was not considered to be experiencing abuse or neglect/self-neglect; the concern was perceived to be about falls and the risk deemed to have been removed. A home visit was not made by the safeguarding team, despite the additional vulnerability owing to her age and lack of support. There wasn’t a conversation with Sylvia and only a text message sent and when there was no response, the concern was closed. The safeguarding team's view is that current practice would necessitate a visit with the helper because of the relationship and as Sylvia was also hard of hearing.

GP records indicate that there was a Lasting Power of Attorney (LPA) in place for health and welfare held by her son.

A Mental Capacity assessment was not undertaken. It is apparent that capacity was assumed whenever Sylvia declined or accepted an intervention or when practitioners were prompted about it in any assessment document or checklist. This was referenced frequently which could imply that when she did appear forgetful or confused or make 'unwise' decisions that practitioners felt that other professionals had already decided she had capacity and did not question as much as they might have otherwise done so. It was noted in July 2024, Sylvia had 'mild cognitive disorder', and a Mini-Mental State Examination (MMSE) score of 26/30, which did not warrant referral to the Older Person's Mental Health Team for a formal assessment.

Cognitive decline was observed toward the end of her life, but this could have been caused or exacerbated by infection, the effect of cold temperatures or a medical condition. It has been suggested that her capacity could have been affected by a cellulitis infection which caused delirium and by small vessel disease diagnosed in the month before she died.

The issues identified above in relation to effective safeguarding responses and mental capacity are repeated system issues which have been identified in previous SARs and have not been effectively addressed.

Were Care Act duties fulfilled?

A Care Act assessment was undertaken in May 2024 and risks and support requirements identified.

The main involvement was by the Adult Intermediate Care Team, and the primary focus was on hospital discharge following the increasingly frequent admissions.

A referral was made for an occupational therapy assessment, and a telephone call was made on receipt. However, Sylvia was in hospital when there was a planned Occupational Therapy (OT) appointment, and she had died before they were able to become involved.

In terms of social work involvement, it seems that it was considered that Sylvia's care and support needs were being met by the homecare agency. Work on reducing risks, falls, self-neglect and hoarding weren’t given prominence. Rather than allocating a social worker, an annual review was planned. A more risk-based approach might at least have indicated an earlier review. It is acknowledged that the request for double up care (having support by two carers) by the homecare agency in early January 2025 would most likely have triggered a conversation with Sylvia to seek her agreement, as she was paying full cost, and then approval of the additional care followed by a review to confirm this and any other changes to her care plan.

It is probable Sylvia was seen as lower risk as it was assumed she had mental capacity and was receiving a fairly intensive package of care from a homecare

agency. Whilst it is not unusual, and limited resources and the requirement to prioritise is a national issue, this resulted in a rather narrow interpretation of fulfilling Care Act duties.

How effectively did agencies work together to understand capacity, and risks such as falls, safety and self-neglect/hoarding?

Medicines at home, continence, community nurses, tissue viability, and the Urgent community response team were all involved. Some of the visits were one off or for assessment. Others were for more prolonged periods of care such as follow up to a SCAS referral following a fall at home and support after discharge from Spinnaker Ward.[1] The notes indicate there was good communication between services and with the GP. However, it was not always known when Sylvia had been admitted to hospital and community nursing staff arriving for visits would find she was not there. During the initial scoping, information was only provided on the involvement of the named GP. Subsequent enquiries showed that there was considerable involvement by the GPs in the Practice e.g. reviews of medication / blood test reviews, referral to a Community Matron, along with other primary care staff.

The key themes from the records were:

- Recurrent falls (environmental hazards, underlying frailty, osteoarthritis)
- Home environment (hoarding, home safety, cold living conditions)
- Medication adherence (self-selection of medication taken).

The cluttered home environment was a prominent concern. According to primary care records, 'hoarding scale 3/4 and later 5' (becoming severe). - see the clutter image rating tool within the 4LSAB Multi-agency Hoarding Guidance. This was increasing the risk of falls and impeding care, but Sylvia was perceived by practitioners as defensive when this was raised and resisted decluttering.

The involvement of the Hampshire & Isle of Wight Fire & Rescue Service was particularly noteworthy. A 'Safe and Well' visit[2] resulted in the installation of two smoke alarms and a carbon monoxide alarm. A clutter rating of 4 was noted as were Sylvia's mobility difficulties; advice was given on an escape plan and nighttime routine, safety with electrical appliances and ways of mitigating the risks. It is, however, unclear if this was communicated to her care workers to reinforce the advice.

As previously summarised, the direct involvement of Adult Social Care was limited and mainly through the Adult Intermediate Care Team, as the primary focus was on hospital discharge following the increasingly frequent admissions. It has been observed that with the Discharge to Assess (D2A) arrangements people are not

[1] Spinnaker Ward is a 12 bed unit that provides Specialist Inpatient Rehabilitation for patients with complex physical disability.
[2] Safe and Well visits are now known as Home Fire Safety Visits. See Home Fire Safety Visit (Safe and Well).

usually seen in their home environment. Care records list five referrals to Adult Social Care and Safeguarding including for Occupational Therapy.

The self-employed helper seemed to be the most significant person in Sylvia's life, especially over her last six months, as she visited three times a week (including when she was in hospital) to provide practical help and companionship. As the daughter and son's involvement reduced, the helper was contacted by the Frailty team at the hospital regarding appointments. Sylvia often called her 'all times of night and day'. She was concerned about the state of her cold house and frequent falls; she thought a move to residential care might have made Sylvia's life easier and enjoyable. She stated in an email 'I felt I had no choice but to raise my concerns with social services... I just felt she was failed'. It seems this related to the referral to the safeguarding team in September 2024.

It is very apparent that the helper was a significant person and most of the various agencies did not communicate with her nor involve her in their work to provide care and support to Sylvia, e.g. as an advocate and source of information.

The risks such as falls, safety and self-neglect/hoarding were recognised but actions were less clear and approaches fragmented. Hoarding was not seen as a mental health issue and the initial relatively low clutter score, the fact that she lived in two rooms and was resistant to change, no doubt reduced the focus on hoarding.

Whilst acknowledging the level of support to Sylvia from a range of agencies, the communications between them was very limited. This meant that the pieces were not put together to develop an overall care and support plan delivered in an effective person-centred and coordinated way. An allocated social worker often has a crucial role in ensuring the different agencies, including homecare, have up to date information on changing needs and circumstances, as well as coordinating more effective delivery of care and health support. As noted above, there is a systemic lack of join-up between different health services in the community and hospital.

How were concerns responded to about possible neglect / acts of omission by the domiciliary care agency?

The homecare agency was commissioned by NHS Hampshire & Isle of Wight (the Integrated Care Board) in April 2024 via a request from the care brokerage team. In June 2024, the funding ceased, and PCC took over the responsibility for the care. Sylvia was paying the full cost, and it seems she/her family were assumed to be responsible for the management of the package of care with minimal involvement from PCC.

Feedback at the workshop included that the Care Brokerage form does not include information on the funder, so the domiciliary agency needs to ascertain this in order to raise concerns with the responsible organisation. The follow up has identified that this information is included at the initial request stage but not updated when the funder changes (the extent of any additional resources requirements has not been assessed). The provider always undertakes a face-to-face assessment before care

commences but reported that information on the person is often out of date. Face-to-face reviews are also undertaken.

In the months prior to Sylvia's death, her family had raised concerns about the service being provided such as carers arriving at a set time / punctually, consistency of carers (so they knew the routines and preferences), and cultural differences (some requests not understood) having an impact on communications (Sylvia was hard of hearing and some carers were softly spoken) and care standards. Visual prompts such as turning on / off the heater at specific times were suggested. It was reported that temporary improvements were not sustained.

Sylvia had a comprehensive care plan, but it was not updated after November 2024 despite her deteriorating health. It stated there was no DNACPR (do not attempt cardiopulmonary resuscitation) although this was found in her home. It is essential that all relevant documents, including care plans and DNACPR records, are kept up to date. The feedback at the workshop is that medical/SCAS/hospital information is not routinely shared with care providers.

A Section 42 Enquiry was undertaken following Sylvia's death and highlighted the importance of adhering to care plans and ensuring safety during cold weather, and strengthening medication administration practices and carers being better equipped to manage medical emergencies. The findings / recommendations have been accepted by the homecare agency. The actions that have been taken are detailed in the section on developments since Sylvia's death.

The perception is that the homecare provider focused on providing support with daily tasks but did not consider it should raise concerns about increasing needs / risks with PCC until a crisis point had been reached.

What practice issues are identified to ensure a more person centred and strength-based approach?

It is acknowledged that most care and health staff sought to provide effective support to Sylvia to mitigate some of the risks and enable her to continue living at home. However, from the records and conversations, it is mainly the helper who seems to have been person-centred. It may be seen as implicit that agencies knew what was important to Sylvia, but her voice does not come across strongly. The focus appears to be on responding to tasks and supporting discharges from hospital.

When a person is resistant to change, opening up conversations on practical matters can be productive. For example, rather than just moving the heater between rooms, supporting access to grants for additional heating / central heating through the Environment Centre[3] and arranging moving of furniture can have a very positive impact. During the workshop, participants expressed the view that there is a gap in being able to commission the moving of furniture to make properties safer. (The 'Man and a van' is a chargeable service.)

[3] the Environment Centre (tEC) – Bringing the benefits of sustainability to everyone

It is understood that Sylvia had a push button rather than a falls pendant so use of assistive technology is another way of people being safer in their own home. (It is recognised that an OT assessment was pending.)

Having an advocate, possibly the helper, could have supported a more person-centred assessment and strength-based approach. This should have helped to develop an overall care and support plan delivered in an effective person-centred and coordinated way.

Mechanisms to achieve this would have been through a review. This was scheduled to be annually, although it would probably have been brought forward because of her increased needs and the homecare agency's request for double up care.

The level of and the increasing risks combined with the number of involved agencies suggests a multi-agency risk management (MARM)[4] approach could have been useful to develop more robust plans and coordinate their delivery.

The questions of how to identify people at risk and who should take the lead arise. Perhaps identification could be through frequent hospital admissions / SCAS call outs and/or homecare agencies providing 4 daily calls but requesting double ups. A possible initiative through the Neighbourhood Health pilot was considered but following discussion with the Integrated Care Board lead, it was decided this would be premature.

Consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

One of the protected characteristics is age: the protection against discrimination based on a person's age. The Care Act 2014 and its wellbeing principle requires that any decisions made from assessment to commissioning should promote a person's dignity, independence, participation and control over their life.

Sylvia was well into her 90s and the responses to meeting her care and support needs strongly suggest these duties were not adequately met. She was probably regarded as 'stoic' or 'formidable' but the above principles were not prominent in the ways agencies responded.

Another protected characteristic is disability: physical and mental, which has a substantial and long-term negative effect on the person's day-to-day activities. This also applied although age was regarded as the most prominent factor.

There were examples of Sylvia's sensory needs not always being recognised, for example sending text messages and telephone conversations not appreciating that she was' hard of hearing'. It is essential that reasonable adjustments are made. This suggests that agencies should gather information on a person's communication

[4] https://www.portsmouthsab.uk/wp-content/uploads/2025/02/4LSAB-MARM-Multi-Agency-Risk-Management-Framework-June-2023-Final.pdf

needs and a small case file audit could identify whether practice on accessibility arrangements requires improvement.

13. Concluding comments

Sylvia was provided with a considerable amount of support from care and health agencies during the last year of her life. The focus was on enabling her to remain at home and when in hospital, arranging early discharge.

A person-centred strength-based approach was not always evident and there was a lack of seeing risks through a safeguarding lens. Concerns about increased needs / risks were either not raised or only when a crisis point had been reached.

It is essential that a person is not seen as an elderly person nearing the end of life, but care and health agencies should always promote a person's dignity, independence, participation and control over their life.

This SAR has highlighted a number of practice issues which should act as reminders relating to safeguarding, strength-based / person-centred practice, care standards and information sharing, rather than recommendations on system changes.

There was a fragmented approach, with a range of tasks / interventions but without a full picture of Sylvia's care and health needs and a comprehensive plan with effective coordination of the provided support.

The level of support to Sylvia from a range of agencies is acknowledged but the communications between them was very limited. This meant that the pieces were not put together to develop an overall care and support plan delivered in an effective person-centred and coordinated way. An allocated social worker, or another named professional, often has a crucial role in ensuring the different agencies, including homecare, have up to date information on changing needs and circumstances, as well as coordinating more effective delivery of care and health support. An identified professional would most likely have arranged an earlier review and also have identified the significance of the paid helper.

The question arises is whether Sylvia should have been prioritised for such an approach and if this is realistic given the number of people with similar needs and the limited available resources. There are currently 353 patients aged 95 and over registered with GPs in Portsmouth (75 of whom are living in care homes). The local Neighbourhood Health pilot has identified as one of its priorities the development of personalised interventions for 'high intensity' service users but following consultation, it was concluded that a related recommendation would be premature.

14. Developments since Sylvia's death

The homecare agency accepted the findings / recommendations of the Section 42 Enquiry and have initiated the following:

- Reminded their staff of the importance of adhering to care plans and ensuring safety during cold weather, including checking room temperatures, using available heating safely, confirming service users are appropriately dressed and that additional blankets are provided when heaters are turned off.
- Taken steps to strengthen medication administration practices through mandatory e-learning and competency checks.
- Introduced measures to ensure carers are better equipped to manage medical emergencies with confidence, including the reissuing and briefing on their Policy on Dealing with Medical Emergencies and their Recording and Reporting Policy.
- The care agency, with the person's consent, has been using GP Connect since summer 2025, which gives information on medication, allergies and health conditions. It has also introduced a care workers' guide to issue to all carers and include for any new carers.

Development of Adult Social Care front door

The Adult Social Care Safeguarding Development Programme is a major improvement initiative that will run throughout 2026.

'This programme has been established in response to the findings of the 2025 Safeguarding Stocktake, and learning from SARs, which highlighted the need for clearer processes, more consistent decision making, improved recording, and stronger safeguarding governance across Adult Social Care. Ensuring that we meet our duties under the Care Act 2014 and deliver high-quality, person-centred safeguarding practice is essential.'

Work is underway on the Front Door to 'strengthen how we manage and respond to all incoming contacts, concerns and referrals.' A significant amount of overlap - particularly around triage, decision-making, and recording - has been identified. A range of work is underway including:

- A clearer and more consistent safeguarding pathway.
- Redesigned Front Door, referral and triage processes.
- Better tools, templates, training and guidance for all practitioners.

Other recent developments

The establishment of a risk panel forum within Adult Social Care to support the identification of risks and actions to mitigate them.

15. Recommendations

a) Commissioners should work with homecare agencies to share the learning from the SAR, especially on measures to mitigate risks during periods of cold weather, strengthen medication administration practices and dealing with medical emergencies.

b) Agencies should gather information on a person's communication needs and a small case file audit could identify whether practice on accessibility arrangements requires improvement.