# Briefing Note

## SAR William

Liverpool Safeguarding Adults Board are today (22.10.2025) publishing a Safeguarding Adults Review (SAR). There has been a delay in publishing this report due to consideration of a further parallel process which has now concluded. During the period of consideration, The Board could not progress to publication until this determination had been reached.

William (a pseudonym chosen by his family) died in Aintree University Hospital in January 2021. He was 81 years of age and had a diagnosis of Alzheimer's, arthritis and had a long-term catheter in situ due to incontinence. He had been admitted to Aintree University Hospital from Nursing Home A on 12th December 2020. The Hospital made two safeguarding referrals relating to the standard of care provided to William whilst a resident of the Nursing Home as when admitted to hospital he was found to have severe acute kidney injury, was malnourished and had serious injuries thought to have been caused by the catheter. The safeguarding referrals were received by Liverpool City Council (LCC) Adult Social Care but were not progressed until William's daughter enquired about the outcome of any safeguarding enquiry in May 2021. The Section 42 Safeguarding Enquiry which then took place found that the concerns that William's care was neglected whilst a resident in Nursing Home A were substantiated.

The SAR panel identified focused learning themes for analysis:

- How effective was William's discharge from hospital to the nursing home
- How effective was William's needs assessed? And were the nursing home effective in meeting William's needs in respect of hydration and nutrition, skin integrity and urinary catheter care
- Were decisions about William taken within a Best Interests framework
- How effective are single and multi-agency arrangements for long term urinary catheter care for people with care and support needs.
- When safeguarding referrals were made in respect of William, were they handled in accordance with policy and procedure
- were the principles of the Care Act – empowerment, prevention, proportionality, protection, partnership and accountability and Making Safeguarding Personal– applied in respect of William?
- Did agencies appropriately share information
- Were there any specific considerations around equality and diversity
- Did the Covid-19 pandemic have any impact on William or the support offered or provided to William by agencies during the pandemic?

A key focus of the review was to identify areas for improved practice including any obstacles or barriers to achieving it, and to highlight areas of good practice.

The Board wishes to record their condolences to the family of William.

The Liverpool Safeguarding Adults Board and its partners fully accept the report and its recommendations. The Board has developed a multi-agency improvement plan to address the recommendations within the SAR report. The purpose of the multi-agency improvement plan is strengthen practice, particularly with regards to Catheter Care, Hydration and Nutrition, and in responding to safeguarding concerns. The Board will be convening a post Safeguarding Adults Review learning event will take place with professionals in Liverpool to explore the key learning from this Review in early 2026.

Duncan Robinson

Independent Chair
Liverpool Safeguarding Adults Board

**<u>Please note</u> a pseudonym name has been selected to help to protect the identity of both the individual and their family.**