Safeguarding Adults Review (SAR)
Executive Summary Report
‘Kathleen’

LIVERPOOL SAFEGUARDING ADULTS BOARD

INDEPENDENT LEAD REVIEWER: MICHELLE GRANT

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1. Introduction

1.1 Kathleen was a white British woman who was in her 70's when she was admitted to Whiston Hospital in April 2023 with an unstageable pressure ulcer to her sacrum, other extensive damage to her skin and further indicators of neglect/self-neglect were recorded on initial assessment by health professionals.

1.2 The previous Kathleen was seen in her own home by a GP at the request of her family. Family reported that Kathleen's health had declined rapidly over the last 4 days and was only taking a small amount of fluid orally. The GP made a referral to the District Nurses (DNs) who visited later that day to assess a pressure ulcer to Kathleen's sacrum observed by the GP at their home visit. During this visit the DNs found Kathleen to be sitting on a hospital bed with an air flow pressure relieving mattress on it. Kathleen was found to have been doubly incontinent in the bed and with her in bed was a baby. The baby was identified as a family member. Kathleen was also smoking a cigarette in the presence of the baby. Kathleen declined hospital admission at this time and was felt by the DNs to have the mental capacity to make this decision at this time.

1.3 Following their assessment of the pressure ulcer the DNs called the GP the following morning and it was agreed that Kathleen needed to be admitted to hospital for treatment of the pressure ulcer which showed signs of being necrotic, as a result an ambulance was requested by the GP to transfer Kathleen to hospital. On arrival of an ambulance crew from North West Ambulance Service (NWAS) Kathleen refused to be transferred to hospital, the crew spoke with the GP, and it was agreed that Kathleen had the mental capacity to make again what might have appeared to be an 'unwise' decision. Worsening condition advice was given to Kathleen and her family before the crew left.

1.4 Later the same afternoon the DN's visited Kathleen for a second time and found her once again to have been doubly incontinent in the bed with baby. At this visit the DNs were able to discuss the seriousness of their concerns for Kathleen's health of not having her pressure ulcer treated and her risk of sepsis if the wound became infected. Following this conversation, and with her family's approval, Kathleen agreed to be transferred to hospital by NWAS.

1.5 On admission Kathleen was reviewed by clinicians, and the severity of her condition was explained to both her and her family. She was noted to have numerous pressure ulcers to her sacrum, back, elbows and hips with extensive superficial damage to the surface of her skin which was also very dry. Fluids were given subcutaneously to rehydrate Kathleen, and she was commenced on intravenous antibiotics for a confirmed wound infection and possible sepsis. Do Not attempt Cardiopulmonary Resuscitation (DNACPR) was discussed with her family, and it was agreed that in the event of a cardiac arrest Kathleen would not be resuscitated due to the seriousness of her condition. Despite active medical treatment following a further deterioration in her physical health over the next few days Kathleen sadly died in hospital on the 16th of April 2023.

2. Commissioning of the SAR

Why the SAR has been commissioned

2.1 A referral for a SAR was submitted to the LSAB on 12th July 2023 by Liverpool City Council following the concerns raised in the Safeguarding Adults Referral made by NWAS staff who transferred Kathleen into hospital in April 2023.

2.2 Initial screening of the referral by the SAR subgroup took place on the 17th of August 2023 where it was agreed that the criteria for a mandatory SAR as per Section 44 (1) (2) and (3) of the Care Act 2014 were met. Condition 1 being that:

- The adult has died **and**
- The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected that abuse or neglect before the adult died).

2.3 Concerns were around the limited agency involvement and knowledge of Kathleen, who had been bedbound for over a decade, and had previously suffered a stroke. Records indicated that Kathleen was not known to ASC, but that from RLUH medical records there was evidence that she had a care package in place from 2013 until 2015 presumably funded by ASC. It was understood from agency information that Kathleen had been provided with a hospital bed and electrically powered mattress but not who had provided this and when, again possibly as a result of her stroke a decade ago.

2.4 Kathleen appeared to have her substantial care needs met by her family. The lack of formal use of the Mental Capacity Act 2005 and hearing the person's voice, in the few contacts professionals did have with Kathleen given her level of need was of concern. The subgroup reflected on the emerging themes from Lessons Learnt Review 18 and SAR 'June'[1] both commissioned by the LSAB demonstrating concerns over the role and support for informal carers, it was agreed that this should be explored further as part of the review of the care of Kathleen.

3. Methodology

3.1 The review has been carried out in a way that reflects the values and principles set out in the SCIE 'Learning Together' approach to reviews. These principles include:

- Avoidance of hindsight bias. That is understanding how different professionals saw the case as it unfolded whilst trying not to be influenced by the knowledge of the outcome
- Providing adequate explanations for the practice encountered - appraising and explaining; and
- Understanding how the specifics in this case can be used to generate wider understanding.

[1] SAR 'June' Executive Summary and Briefing Note published November 2024 https://liverpoolsab.org.uk [Accessed December 2024]

3.2 The independent author was given access to the SAR referral form and screening panel minutes as well as summaries of agency involvement by those that were working with or had seen Kathleen within the timeframe of the review which was agreed as being from April 2022 to April 2023 when Kathleen sadly died.

3.3 Following a review of these documents the independent author posed several questions to agencies to clarify involvement or seek further additional information. Following discussion at the first panel meeting held on 23rd of October 2024 a draft terms of reference was suggested and agreed. The benefit of a practitioner learning event was also discussed, the panel concurred that this would not add meaningful value to the review and that a desk top review of available information and relevant research findings would provide the learning required. It was agreed instead that the independent author would meet with the GP safeguarding lead and the ICB representative to review the care of Kathleen prior to the new management team taking over the surgery, and to identify which practices have changed since 2006 that would strengthen the support offered to people like Kathleen who relied on their family as informal carers and by primary care to identify any further learning that needs to be taken forward.

3.4 A second panel meeting was held on 11th of February 2025 to consider the first draft of the review report and to discuss the learning themes. Following this meeting it was agreed that the draft report could be approved by panel members via e-mail confirmation without the need for a further panel meeting. The report was finally approved remotely by panel members on the 16th of May 2025.

3.5 Noting that Kathleen had a baby in bed with her when seen by practitioners in April 2023 the independent author and panel members have also considered the findings of the review from a children's perspective to address this potential child protection issue.

3.6 Children's Social Care were notified in relation to the concerns over the care of the baby, as a result contact was made with the family. Following this review a decision was made that no further action was required, as there was no evidence of potential neglect identified.

4.0 Terms of Reference

- How do primary care and community teams manage repeated non-engagement when 'access is denied' by carers/family and the person is dependent of the support of others?
- Are there robust systems in place across health and social care to flag adults for whom there are concerns as above in relation to considering a safeguarding/MDT approach?
- What were the barriers to communicating with Kathleen? why was family speaking on Kathleen's behalf when there were no concerns about Kathleen's ability to communicate herself?
- Why was Kathleen's family not offered a carer's assessment?
- What processes failed when arranging follow ups to investigate Kathleen's abnormal clinical recordings?

- Do practitioners working across Liverpool City Council's boundary understand the criteria for assessment of need?
- Do practitioners working across the Liverpool City Council boundary understand the criteria for a needs assessment under the Care Act 2014 and how to support people accessing one?
- Do practitioners understand the process for requesting a needs assessment?
- Do Liverpool City Council need to do more publicity to enable the public to know they can request an assessment of need under the Care Act 2014 if the criteria are met?
- How can the LSAB be assured that there is a robust system in place across both health and social care ensuring checks on electrical equipment provided for use in a person's home are in line with manufacturers and MHRA guidelines.

5.0 Panel Membership

Panel Members for SAR 'Kathleen'	
Role	**Representation**
Independent Author	
Designated Nurse	Integrated Care Board Liverpool Place who supported the GP involvement in the review
Safeguarding Practitioner	North West Ambulance Service who attended Kathleen on 2 occasions in April 2023
Adult Safeguarding Lead	Mersey Care NHS Foundation Trust who provided Phlebotomy and District Nursing input
Head of Safeguarding and Assurance	Liverpool City Council who undertook an adult safeguarding enquiry
Adult Safeguarding Board Manager	Hosted by Liverpool City Council
Minute Taker Adult Safeguarding Board Support Officer	Hosted by Liverpool City Council

6.0 Equality and Diversity

6.1 The author and panel members have considered the 9 protected characteristics under the Equality Act 2010[2], both age and disability would apply to the care and treatment of Kathleen.

6.2 The SAR does not find any documented evidence that Kathleen was treated differently by professionals based on either her age or physical disabilities. She was actively encouraged to attend hospital when appropriate to do so, and on admission to hospital in April 2023 she was actively treated for sepsis until her medical condition deteriorated further.

7.0 Family Engagement

7.1 The independent author and panel members recognise the importance of involving the person, their family, and friends in understanding the lived experience of the person who is the subject of the SAR and how their family supported them in a caring role.

7.2 Despite repeated attempts to engage the family and without details of any friends of Kathleen it has not been possible to source anyone who can provide the review with any additional understanding of the family dynamic and lived experience, as well as any barriers that Kathleen or her family may have felt prevented wider engagement with outside agencies.

7.3 Information contained within the SAR is therefore taken from agency information known about Kathleen and her family. The use of the pseudonym 'Kathleen' was agreed by the panel to protect the privacy of her family.

8.0 Good Practice

8.1 Liverpool Children's Social Care (CSC)

8.1.1 The conditions Kathleen's family member baby was being cared for in were shared with CSC in April 2023 at which point they became involved in the safety of the baby in Kathleen's home.

8.2 Liverpool Adult Social Care (ASC)

8.2.1 The safeguarding enquiry was kept open following notification of Kathleen's death to enable identification of 'early learning'. This included a reflective session between ASC and MCFT staff.

[2] The Equality Act 2010 9 characteristics: Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, sex and sexual orientation https://www.legistlationx.gov.uk

8.3 Mersey and West Lancashire Teaching Hospital (Whiston Hospital)

8.3.1 The Emergency Department staff discussed safeguarding concerns with their internal safeguarding team following the clinical assessment of Kathleen.

8.4 Mersey Care NHS Foundation Trust

8.4.1 The diligence of the Phlebotomy service staff in making repeated attempts to see and obtain bloods from Kathleen in 2021 and 2022 was above what would be 'normal practice'.

8.4.2 The DN who saw Kathleen on the 14th of April 2023 used all their professional experience in being very clear with Kathleen that her health was at serious risk of deterioration should she not accept care, and that the possibility of an infection in her pressure ulcer if left untreated could lead to sepsis from which she might not recover.

9.0 Agency Developments following the death of Kathleen

9.1 GP Practice

9.1.1 The GP practice has a named safeguarding lead who is known to all practice staff. They have reviewed their safeguarding policy and procedures and also have in place a policy that covers Did Not Attend (DNA) and Was Not Seen (WNS). Any patient reliant on others to support them in attending the practice or allowing professionals to see them at home will be brought to the attention of the safeguarding lead at the practice and will be discussed at their Bi-monthly vulnerable people meeting. A DNA on 3 occasions would also be considered to review any vulnerabilities that should raise a concern.

11.1.2 Since the takeover of the practice all clinical staff have been trained to a level 3 standard as per the Adult Safeguarding: Roles and Competencies for Health Care Staff[3]. The safeguarding administration team at the practice have also been trained to level 3. Level 3 training is above what the intercollegiate document requires for non-clinical staff. The safeguarding lead felt it was important to have the safeguarding administration team trained to this higher level to ensure a clear understanding of how safeguarding should come together to work effectively.

11.1.3 The practice has also trained their administration staff to add read codes to a patient's GP record when appropriate to do so and to allocate a 'task' to a GP to review incoming information relevant to that patient.

11.1.4 The safeguarding lead at the practice has already discussed their findings from a review of Kathleen's record with the executive team at the practice was part of this SAR. On conclusion of this SAR the safeguarding lead will share the learning from the review at a future practice Protected

[3] Adult Safeguarding: Roles and Competencies for Health Care Staff https://www.rcn.org.uk 29th July 2024

Learning Time (PLT) event. The learning will be broken down into learning for reception and administration staff and learning for clinical staff.

10.0 Conclusions

10.1 For the time frame of the SAR there were only a few identified face to face contacts by professionals, in late 2022 when the GP saw Kathleen in her own home and requested blood testing. The phlebotomists then attempted to obtain blood from Kathleen and were unable to do so until after numerous attempts blood was eventually obtained in November 2022. She was then not seen again until the day prior to her hospital admission in April 2023.

12.2 The review finds that the management of the GP surgery that Kathleen was registered with missed a number of opportunities to be both professionally curious and to consider action to be taken following the reports of missed hospital appointments, lack of access when attempting to obtain blood samples by phlebotomists and in attempting to undertake ear syringing by the DNs the GP surgery had requested.

12.3 At the time of Kathleen's care Liverpool Clinical Commissioning Group (LCCG) held the responsibility for the contractual processes for GP surgeries within Liverpool. The contractual process is outlined within the GP contract and policy manual guidance, to manage this Liverpool CCG had the following in place:

- Primary Care Management Committee
- Primary Care Committee

12.4 In relation to the practice management prior to Primary Care 24 taking over the practice there were contract, quality, performance and estates meetings with the Lead GP. The issue of poor staffing at the practice was raised and discussed due to safeguarding referrals made to Liverpool Local Authority in July 2021. A GP practice Quality Assurance visit was conducted, following this visit an action plan was produced and monitored on a monthly basis and discussed at the Primary Care Committee. It was agreed that in June 2023 the practice would be taken over to improve safe and effective quality measures.

12.5 From a review of written records there is no evidence to suggest that professionals had concerns about how Kathleen presented in terms of neglect/self-neglect and no reference to the home environment being unsafe for Kathleen to live in when she was seen in her own home by GP staff. A review of contacts predating the time frame again demonstrates limited opportunities for contact with Kathleen and on these occasions no concerns relating to the care of Kathleen or carer stress on the family appear to have been raised by other healthcare professionals.

12.6 The second national analysis of Safeguarding Adult Reviews[4] compares the percentages between the first and second national analysis of SARs which identified cases featuring concerns

[4] Second national analysis of Safeguarding Adult Reviews https://www.local.gov.uk published 12th June 2024

relating to partners, relatives, friends or unpaid carers increasing from 19% to 25%. Findings on lack of organisational support were noted, the analysis also identified shortcomings in the offer and completion of carers assessments and reliance or over dependence on family carers.

12.7 The second finding in the national analysis titled 'safe care at home' found that there were instances where situations were seen through the lens of carers stress rather than curiosity about the relationship dynamic between the carer and the cared for person, and whether there was evidence of abuse or neglect. An absence of professional curiosity and an avoidance of difficult discussions concluded that this could result in the risk not being recognised or addressed.

12.8 The report highlights two improvement priorities which Safeguarding Adult Boards (SABs) should consider seeking assurance over. The first being that the local authority provides the SAB with performance data on carers assessments and the second being assurance about levels of oversight of care at home, with actions to evidence partnership working both operationally and strategically between community safety, adult safeguarding practitioners and managers.

12.9 The discontinuation of the care package that Kathleen had in place from 2013 to 2015 was a significant missed opportunity by health and social care providers to explore the reasons for this decision and to evidence how they were assured that leaving Kathleen in the care of her family would not pose a risk to both her and her unpaid carers.

12.10 The independent author and panel members had confirmation from the panel member from ASC that the record keeping retention period for adult social care records is 8 years[5] from last contact, and therefore there is no record of ASC funding the care package from 2013 to 2015 indicated in the healthcare record of Kathleen held by RLUH. As a result, there is no opportunity to review what conversations were held with Kathleen and her family about requesting support in future if the removal of the support led to the need to request help again in the future.

12.11 Both the independent author and panel members recognise the invaluable role that family carers provide to their loved ones, but we also need to ensure that services support family members to provide care that is safe both for the person who requires care, but also to those that are delivering the care. The learning identified from this review will support the processes designed to provide this level of assurance.

[5] Records Management Code of Practice https://transform.england.nhs.uk

Learning from SAR 'Kathleen'
Learning 1: The findings from this SAR are the same as a system finding from SAR 'June' commissioned by the LSAB in respect of health partners lacking effective systems to monitor patients who miss repeated appointments or when no access to the person was possible due to carers preventing contact.
Question 1 – How will the LSAB be assured that the learning from the earlier recommendation in SAR 'June' about Did Not Attend and Was Not Brought policies is being embedded across health and social care, when to trigger practitioners to discuss with their safeguarding leads, and whether there has been any progress on ICT systems flagging missed appointments both internally and ideally with other partner agencies? ***(Multi Agency Partners)***
Learning 2: The findings from this SAR are the same as a system finding from SAR 'June' in respect of whether the LSAB endorses the Team Around the Person approach to improve coordination of health and social care and strengthening early health measures to stop safeguarding risks escalating.
Question 2 – How will the LSAB be updated on the progress against this proposal and if not achievable what alternative option/s is/are there? ***(Multi Agency Partners)***
Learning 3: The improvement priority identified in the second national analysis of SARs relating to SABs receiving assurance from their Local Authority providing data on carers assessments is a priority the LSAB should adopt as a result of the findings from this review and previous reviews.
Question 3 – How will Liverpool City Council provide the LSAB with data relating to carers assessments to provide assurance that these assessments are being readily undertaken, and within what timescales? ***(Liverpool City Council)***
Learning 4: The improvement priority in the second national analysis of SAR's relating to SABs receiving assurance from their Local Authority about levels of oversight of care at home with actions to evidence partnership working both operationally and strategically is a priority the LSAB should adopt as a result of the findings from this review and previous reviews.

Question 4: How will Liverpool City Council and its partners provide assurance to the LSAB that this identified priority is being addressed? ***(Multi-Agency Partners)***
Learning 5: The review has identified that there were a significant number of missed opportunities for the practice staff to have been professionally curious about Kathleen's decisions to refuse care and treatment and her failure to engage. The practice is now under new management.
Question 5 – How will NHS Cheshire & Merseyside provide assurance to the LSAB that the changes made to strengthen clinical oversight and safeguarding procedures at this practice are in place and embedded? ***(NHS Cheshire & Merseyside)***
Learning 6: The review has identified that more needs to be done to assist the public in knowing about the Councils 'wellbeing offer' how to apply for a 'carers assessment' or a 'needs assessment', particularly if they have no access to a computer.
Question 6 – How will Liverpool City Council and its partner agencies raise the awareness of the general public about the above. ***(Multi Agency Partners)***
Learning 7: The review has identified that there is a lack of documentation by agencies to record whether Kathleen had given her permission to allow her family to speak on her behalf rather than speaking to her directly or accepting what they were told by family members about Kathleen's views. There is no documentation to support that Kathleen had an LPA in place in the event she lost the capacity to make her own decisions.
Question 7: How will the LSAB be assured by its partner agencies that this finding is shared with practitioners and that action is taken to reduce the likelihood of similar findings in future? ***(Multi Agency Partners)***
Learning 8: The review has identified that Kathleen had electrical equipment in her home provided by partners of the LSAB that potentially had not been checked for safety for a prolonged period of time which had the potential to pose a fire risk at the property to someone who was bedbound.

Question 8: How will the LSAB be assured that there are robust procedures in place for safety checks on electrical equipment to reduce risk to vulnerable people? ***(Health and ASC)***

4. Glossary of Terms

ASC	Adult Social Care
CSC	Children's Social Care
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
GP	General Practitioner
ICB	Integrated Care Board
LCC	Liverpool City Council
LCCG	Liverpool Clinical Commissioning Group
LPA	Lasting Power of Attorney
LSAB	Liverpool Safeguarding Adults Board
MCA	Mental Capacity Act 2005
MCFT	Mersey Care Foundation Trust
MDT	Multi-disciplinary Team meeting
MHRA	Medicines & Healthcare products Regulatory Service
NWAS	North West Ambulance Service
PLT	Protected Learning Time
RLUH	Royal Liverpool University Hospital
SAR	Safeguarding Adults Review