Derbyshire Safeguarding Adults Board

Learning Brief for practitioners and managers

Safeguarding Adult Review: SAR23A ‘Mary’

August 2025

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BACKGROUND

Mary was a white British woman with moderate to severe learning disabilities. She had lived in a nursing home in Derbyshire for almost 30 years. She was in her 60s when she died in hospital in 2022. She had been admitted to hospital with pressure damage to her skin which had occurred at the care home.

In the week following Mary's admission to hospital, she developed further areas of pressure damage. Mary's placement at the care home ceased following her hospital admission, with an alternative being found for her discharge; however, Mary sadly died in hospital from septicaemia and an infected sacral pressure ulcer.

Mary's mobility was affected by a fall 3 years before she died, and from this point she used a wheelchair. Mary had periods of time where she refused food and fluids and would stay in bed for prolonged periods of time when she felt upset or unwell.

Mary's family had a close relationship with her throughout her life and visited her regularly. They provided valuable information for this Safeguarding Adult Review.

The review period included the Covid-19 pandemic and the periods where restrictions and lockdowns were in place between March 2020- March 2022.

LEARNING FOR PRACTITIONERS AND MANAGERS

ASSESSMENT AND TREATMENT OF PHYSICAL HEALTH NEEDS

The safeguarding adult review highlighted challenges for both community and hospital health services when they are assessing and treating the physical health needs of people with learning disabilities, particularly when the person is unable to communicate. Mary's refusal to eat and drink had resulted in physical health deterioration.

Derbyshire Community Health Services provided information in relation to actions already taken in relation to this finding: *The referral to the Learning Disability service is triaged initially to ensure the learning disability criteria are met. The referral is reviewed to identify the need for specialist services at a Single Point of Access (SPOA) meeting. When accepted, staff will visit the patient to complete a Patient Plan of Care (PPoC) which includes physical health needs.*

PRESSURE AREA CARE MANAGEMENT

The management of Mary's pressure area care at the care home was found to be inadequate, in both prevention and treatment. Care home staff were not sufficiently aware of how to refer to specialist services for pressure ulcer care.

For people who are at high risk of developing pressure damage while in nursing care homes, assurance is required that staff are aware of how to make an appropriate referral to specialist services.

SAFEGUARDING IN NURSING CARE AND HOSPITAL

Where a person's needs for care and support have increased as a result of a deterioration in their health and a hospital admission, this should prompt a review of their placement preferably prior to, or after discharge from hospital, to ensure that the person's needs are met.

IMPACT OF COVID-19

The Covid-19 pandemic impacted on Mary's care, with lockdowns and staff shortages affecting the quality of care and oversight provided by the care home. The care home Mary resided in has since closed down following an inadequate inspection rating from the Care Quality Commission (CQC).

POSITIVE PRACTICE

HOSPITAL CARE

During Mary's hospital admissions at Chesterfield Royal Hospital, there were examples of staff demonstrating good practice in managing her immediate health needs, including the use of best interests meetings and multi-disciplinary discussions to plan her care. Mary's family described examples of person centred care from the Doctors and Nurses who looked after Mary.

RECOMMENDATIONS

Eight recommendations were made in this review related to the following themes:

- Multi-agency working
- Training and awareness
- Safeguarding processes
- Review and oversight

RECOMMENDATION 1

That where the cause of a change in behaviour for a person with a Learning Disability is unknown and may be due to either a physical and/or a psychological reason, referrals for assessment are improved, utilising existing Multi-Disciplinary Team approaches where someone with a complex presentation would benefit from this approach to allow for identification of appropriate referrals into secondary care services.

RECOMMENDATION 2

Derbyshire Safeguarding Adult Board should request a survey to be undertaken across nursing homes to establish that staff know how to refer into specialist services when residents have pressure ulcers that require specialist support.

RECOMMENDATION 3

Derbyshire Safeguarding Adults Board should develop and promote widely practice guidance for organisational abuse, to include referral information and expectations, and related processes under section 42 Care Act 2014.

RECOMMENDATION 4

Derbyshire County Council Adult Social Care is to provide assurance to the DSAB that information available to Contracts & Commissioning Teams about services is shared across Adult Social Care to ensure it is flagged up for consideration of any subsequent safeguarding concerns about individuals put at risk within these services.

RECOMMENDATION 5

Derbyshire Safeguarding Adults Board to create guidance on joint reviews and expectations of all agencies that include requirements for prompt reviews and sharing of information when aware that there are concerns regarding deteriorating health of adults with learning disabilities in nursing care homes.

RECOMMENDATION 6

Derbyshire County Council's DoLS team to strengthen its communication with care homes and hospitals. This will further remind them of their duty to report significant changes to DoLS teams, including if the person's restrictions or objections increase significantly or if a DoLS Authorisation is no longer required. Recent case notes to be checked on Derbyshire County Council's electronic recording system before DoLS authorisations are granted, in case the DoLS team has not been alerted to significant changes.

RECOMMENDATION 7

Derbyshire Safeguarding Adults Board to undertake an audit of provider led enquiries and provide feedback to partners in relation to any organisation failures with the section 7 Duties to Cooperate (the Care Act 2014), including relevant reasonable timescales for completion.

RECOMMENDATION 8

Derbyshire Safeguarding Adults Board Policy and Procedures subgroup to update the guidance regarding the section 42 enquiry form, to differentiate between information requests and delegation of a section 42 enquiry with clear escalation routes if information/investigation has not been received in a timely manner, with guidance on professional judgement as to when it is appropriate to close the safeguarding when information has not been received but has no impact on the outcome of the enquiry.

NEXT STEPS

The purpose of a Safeguarding Adult Review is for practitioners, managers, and agencies to learn and improve the services provided to people.

The Derbyshire Safeguarding Adults Board has developed an action plan to ensure that the learning identified in this review is implemented.

Please take some time to reflect on the findings from the review.