Learning On One Page (LOOP)

Safeguarding Adults Review (SAR23A Mary) – August 2025

Background/circumstances leading to the Review

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.

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.

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 septicemia and an infected sacral pressure ulcer.

Areas for improvement

The 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.

The treatment of Mary's pressure area care was inadequate. Care home staff were not sufficiently aware of how to refer to specialist services for pressure ulcer care.

When Mary's needs for care and support increased as a result of a deterioration in her health and a hospital admission, this should have prompted a review of her placement preferably prior to, or after discharge from hospital, to ensure that her needs were met.

The Covid-19 pandemic impacted on Mary's care, with lockdowns and staff shortages affecting the quality of care and oversight provided by her care home.

Positive practice

During Mary's hospital admissions 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.

Key Learning Themes

- Assessment and treatment of physical health needs for people who have a learning disability.
- Pressure area care management
- The relationship between Safeguarding, Organisational abuse, and improvement work to regulated services.
- Timeliness of Safeguarding processes and S42 enquiries
- Impact of Covid-19 on services

DSAB recommendations

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

- Multi-agency working
- Training and awareness
- Safeguarding processes
- Review and oversight
- Deprivation of Liberty Safeguards (DoLS) communication

The recommendations can be found in the separate SAR23A learning brief document on the DSAB website.

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