Telford and Wrekin Safeguarding Adults Review (SAR)

Overview Report

Violet

May 2024

SAR Independent Author: Simon Steel

Completed 16th August 2025

This Safeguarding Adult Review would not have been possible to undertake without the co-operation, open reflection and information supplied by those agencies who provided care and support for Violet. This contributed significantly to the production of the final report and helped to identify recommendations for improvement. The input and professional support provided by the Safeguarding Adults Board managers and support staff have been invaluable throughout this process.

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1. Introduction and Background

1.1 Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1.2 The Telford and Wrekin Safeguarding Partnership (TWSP) has accepted the request for a Safeguarding Adult Review (SAR) to be conducted into the circumstances surrounding the death of Violet on the 15th of May 2024 at a hospital in Telford. At the time of her death Violet was 75 years of age.

1.3 The SAR panel agreed that the situation met the Care Act Safeguarding criteria for a SAR; specifically, the criteria that procedures may have failed and that the case gave rise to serious concerns about the way in which local professionals and/or services work together to safeguard adults at risk.

1.4 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity. The principles apply to the Review as follows:

Empowerment:	The Review will seek to understand how the agencies listened to/heard and engaged with Violet and applied Making Safeguarding Personal. Involving Violet's family in the Review.
Prevention:	The learning will be used to consider actions for prevention of future harm to others, particularly in relation to holistic, person-centred planning.
Proportionality:	Understanding whether least restrictive and person-centred practice was used; being proportionate in carrying out our Review objectively.

Protection:	The learning will be used to inform ways of working, actions and professional curiosity to protect others from harm.
Partnership:	Partners will seek to understand looking through the lens of person-centred working, how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process.

Glossary

Name	Abbreviation
District Nurses	DN
Electronic Patient Records	EPR
Emergency Department	ED
Individual Management Reviews	IMR
Making Safeguarding Personal	MSP
Package of Care	POC

2. The Purpose of the Review

2.1
- Establish what lessons can be learned from the Violet's story
- Analyse how organisations work together
- Analyse and expand upon the findings of the various reports
- Commission a final report that will collate the above and make effective recommendations for change; be that to culture, procedures, processes, or policy
- Facilitate a practitioner's event to enable professionals to review the findings of the SAR and identify ways in which the recommendations can be developed and implemented

2.2 This specific SAR is to consider if or how organisations, individually and collectively, may have worked better to correctly assess the needs of Violet from the 1st of January 2024 up until her death on the 15th of May 2024.

3. What do we know about Violet.

3.1 Violet was born in 1949 and was a White/British lady who lived in a Wrekin Housing Group (WHG) bungalow with her son who helped provide care to Violet. Violet's daughter, lived at a separate address and claimed carer's allowance as her mother's carer. Her daughter advised she was the second carer if her mum was having a difficult day. Violet used a self-propelled wheelchair. She attended a day centre and enjoyed getting involved in crafts, puzzles, seated exercise and singing.

3.2 Violet had a care package funded by Telford and Wrekin and delivered by Prayngel. 2 x care calls a day Carer's supported with washing, dressing, showering and medication prompts. Violet liked to shower twice weekly (Wednesday & Sunday) and needed support to wash in between those times.

3.3 Violet had complex health challenges which included:

- She had reduced mobility, right side weakness following a history of strokes which also affected her speech.
- Ulcerated legs

4. Methodology and Process Information

4.1 The author was appointed to undertake the SAR in December 2024.

Organisations Involved

4.2 Combined chronologies were supplied to the author completed by a safeguarding adult lead from the organisations involved. In addition, Individual Management Reviews (IMR) or agency reports were requested where indicated. The agencies involved included:

- Primary Care (GP) IMR
- Adult Social Care (ASC) IMR
- Shropshire and Telford Hospitals NHS Trust (SaTH) IMR
- Shropshire Community Health NHS Trust (SCHT) IMR
- West Midlands Ambulance Services – (WMAS) Report
- Wrekin Housing Group (WHG) IMR

4.3 Following the initial review of all the information, a number of key lines of enquiry (KLE) were identified.

1. **Was appropriate medical attention sought at the relevant times for Violet?**

   - What actions were taken if it was felt by an agency the family were not seeking medical attention?
   - How was this recorded?

2. **Was hoarding identified by agencies? If so, what action was taken?**

   - Is evidence provided anywhere for hoarding?

   - Was any contact made with the relevant housing group to raise this as an issue?

   - Was this discussed with the family?

3. **Were agencies able to effectively communicate with the Primary Carer?**

- Do records clearly identify a primary carer for Violet?

- Was appropriate contact made with the Primary Carer to address concerns?

4. **Were safeguarding concerns identified and dealt with appropriately? Is this clear in the records?**

- Were safeguarding concerns reported and dealt with in the timely manner?

- What efforts have been made to follow up any safeguarding concerns raised in regard to outcomes?

5. **Was Violet's voice heard? Was Violet able to share concerns of her own?**

- Do records clearly identify Violet's voice?

- Was Violet spoken to alone away from primary carers?

- Did Violet raise any concerns of her own? What action was taken as a result of this?

5. Edited Chronology and Summary

5.1 In order to better understand the interactions between the various agencies and departments involved in the care of Violet, the author produced a combined chronology. This provides a timeline of events and describes the contact and care that took place prior to her death. Some of the **key** entries are summarised below within the scoping period 01.01.2024 to 14.05.2024.

5.2 **January 2024**

On the 2nd **DN** visit to Violet for wound assessment. Wound dressed, and advice given to keep areas clean and dry, and maintain a nutritional diet and fluid intake. Plan to follow up with twice weekly visits.

On the 5th Violet attended **GP** for a blood pressure check.

On the 5th 8th10th 12th **DN**

visit to Violet to redress wounds to toes.

On the 12th Violet's Annual assessment from **podiatry service**. Visit to Violets home. Follow up email sent to vascular team to see when Violets next appoint is, and request reports of previous tests.

On the 18th **DN**

visit to Violet to redress wounds to toes. Daughter reported that Violet was attending day centre today and usual visits are Friday's. DN team to liaise and reschedule next visit.

On the 19th **DN**

visit to Violet to redress wounds to toes. No answer, telephoned daughter and informed they had forgot the **DN** team were visiting and were out shopping. DN team informed that visit would be next Friday.

On the 26th **DN** visit to Violet to redress wounds to toes. Violet declined check of pressure areas, stated all intact.

On the 30th **DN** visit to Violet to redress wounds to toes.

5.3 February 2024

On the 2nd **DN** visit to Violet to redress wounds to toes. Identified new ulcer to second toe.

On the 6th 9th 13th 16th **DN** visits to Violet to redress wounds to toes.

On the 20th **DN** visit to Violet to redress wounds to toes. No answer at the door. No answer when attempting to ring landline. Contacted GP to check and stated no evidence of hospital admission, and that they spoke to Violet this morning. Posted card through Violet's letterbox. Next visit planned for 23rd. Visit took place on 23rd as planned.

5.4 **March 2024**

On the 5th **DN** received a call from Violet's daughter to say she was going out and they had waited in long enough today. DN Advised can visit any time up until 5pm. Daughter said they would be going out and could DN visit as planned on Friday. Advised for daughter to monitor for any signs of infection as dressing hasn't been changed for over a week.

On the 8th **WHG** carry out home visit to de-clutter DN arrived to renew dressing to Violet's foot. WHG asked if Violet could have a hospital bed; due to limited mobility which impeded getting into and out of bed. The bed was delivered on the 20th.

On the 8th **DN** email to GP to discharge into the care of the practice nurse from next week as patient is non housebound. DN identified that Violet is not house bound therefore not suitable for continuing to be seen by DN service. Also, that day DN visit to Violet to redress wounds to toes. WHG staff were present, from the enablement support team who were there to help declutter and sort through all the hoarding that had been going on in the property. Requested for the DN's to get a profiling bed for Violet as she does not leave her wheelchair other than to sit on an old armchair where she sleeps. Funding is being looked into to purchase a rise recliner. Advised Violet to attend the practice clinic for dressing changes which she was in agreement with. Appropriate identification that Violet would be better placed to attend practice clinic for dressing change.

On the 10th **DN** placed equipment order for Solite profiling bed Community single mattress.

On the 12th Violet had her last outpatient contact when she was discharged from the Vascular surgery clinic by **SaTH.**

On the 15th 19th 22nd Violet attended **GP** surgery for dressing of toe.

5.5 **April 2024**

On the 9th Violet attended clinic to see the Podiatry service. Violet reported to the podiatrist that she has not attended clinical for her feet as they were ok. Podiatry requested correspondence from vascular team to help inform treatment planning. Podiatry have arranged to review Violet in 4 weeks' time. Email received from vascular team to podiatry service, if any ongoing concerns for podiatry team to get back in touch with the vascular team.

On the 12th 18th Violet attended **GP** practice for dressing of toe.

GP. On the 16th Violet suffered from a burn to the scalp from when she went to light a cigarette. 111 report states there were flames on her scalp. That day Violet had an appointment with a **PN** which was cancelled by the family at 9am. She had contacted 111 at 10.34 (after cancelling appt with GP).

GP. On the 17th Violet saw the GP, had a superficial burn on her forehead. She was in the company of her daughter who reported that "yesterday morning – mum used the toilet and went to the bedroom. Brother was at home at the same time, then she heard a shout, went in and saw her in flames, brother helped also in putting out the fire". Apparently, Violet went to light a cigarette and ended up setting her hair on fire. Called 111 afterwards, here for review. A superficial burn injury noted across forehead and burnt hair noted. Discussed with PN for dressing. Also informed daughter that safeguarding will have to be raised, she consented to this. Violet saw the PN for dressing of the burn of forehead. Violet was not keen on the head dressing but needs to be kept clean and protected from infection, dressed with daughters' consent. The GP who saw Violet and sent a safeguarding referral to family Connect.

ASC on the 17th there was a Safeguarding Contact Referral from Woodside GP Practice: *"Patient lives with son, daughter was around yesterday. Patient tried lighting a cigarette and burnt her hair and forehead. Patient had right sided weakness."* Contact screened by duty and not progressed to Safeguarding Process. Accessed health support through GP (referrer).

GP on the 22nd Violet attended for several dressings with the Practice Nurse. Superficial burn of forehead, dressing, dressing of ulcer and toes redressed.

ASC on the 23rd there was a Safeguarding Contact Referral Prayngel Care Agency: *"There are concerns of possible neglect by family member (s). In the form maintaining the general well-being by failing to contact a GP when required and or attending medical appointments."* Subsequent contact did not identify any specific neglect beyond a concern about family putting a plastic covering over a sore on Violet's leg. Whilst a plastic covering over her leg may not be clinically appropriate it would not indicate abuse in by itself. More importantly the only other issue raised by the agency was family failing to access medical appointments. On direction from the Safeguarding Officer, the agency advised that the GP had confirmed that all medical appointments were being attended. As there was not sufficient evidence of abuse or neglect and she was being reviewed clinically this did not progress through the Safeguarding Process. The contact was closed with advice to the referrer/agency to raise any further concerns regarding requiring medical attention to relevant medical professionals.

GP On the 23rd 24th Violet attended for dressing of ulcer with the Practice Nurse.

On the 24th **WHG** called Family Connect to request a re-assessment of Violet's Care & Support needs. They discussed their concerns, also expressed safeguarding concerns. ASC stated a safeguarding had already been received (likely from GP). WHG were informed that ASC would send them a form to complete re re-assessment of care & support needs. Which was completed and submitted on the 26th. A reply was received advising Violet needs to be referred to Moving and Handling or if her wheelchair is too small then contact Wheelchair Services (numbers given).

GP on the 25th Violet attended for blister of foot with the Practice Nurse. Attended with son and daughter. She has had a visit from Telford and Wrekin Council but not from social worker. Daughter advised that the referral is to provide more help with care for Mum because of recent accidents.

GP on the 26th Violet attended for blister of foot with the Nursing Associate.

WHG on the 26th contacted AT Fire Safety Officer- arranged visit for 1st May.

GP on the 29th 30th Violet attended for blister of foot. Violet attended with daughter.

5.3 **May 2024**

GP on the 1st Violet attended for blister of foot with the Practice Nurse. Attended with son and daughter.

GP on the 2nd Violet attended for blister of foot with the Practice Nurse. Attended with daughter.

GP on the 3rd Violet attended for blister of foot with the Nursing Associate. Violet attended with son and daughter for redress of blisters to right leg.

ASC on the 3rd there was a Safeguarding Contact Referral from WHG: Concerns regarding deterioration in Violet's health and increased care needs. Assigned for urgent Care Act Review. Family Connect sought advice from Adult Safeguarding Team. Referral was primarily stating that additional support is required. This was assigned for an Urgent Care Act Review.

GP on the 7th Violet attended for blister of foot with the Healthcare Assistant. Attended with daughter.

GP on the 8th Violet attended for blister of foot with the Healthcare Assistant. Attended with daughter and son.

On the 8th **WHG** Called ASC FC to ascertain date/time of visit, no date/ time had been logged on the system and made a note for someone to call WHG to let them know. WHG expressed concern that Violet visits the GP nurse on a regular basis and did not want to miss the appointment. Advised someone will call back.

On the 9th **WHG** Called GP practice to ask for an urgent appointment; secured for 5.15pm. Met Violet at GP Practice and attended appointment to express concerns re decline in physical health. GP prescribed 28 days of 'ensure Drinks' and liquid paracetamol.

GP on the 9th Violet attended for blister of foot with the Practice Nurse and also an appointment with the GP. Difficulty in swallowing for weeks now that has led to weight loss.

GP on the 10th Violet attended for blister of foot with the Nursing Associate. Violet attended with daughter.

On the 10th **WHG** Voice mail from ASC Duty Worker and returned call. WHG advised had serious concerns about Violet's health and that she is a high fire risk; explained recent events. Advised a Social Worker was being allocated.

GP on the 13th Violet attended for blister of foot with the Practice Nurse. Attended with son and daughter. Violet seems brighter in herself and has managed to eat a pot noodle and is taking Ensures (Oral nutritional supplements).

GP on the 14th Violet attended for blister of foot with the Practice Nurse. Daughter cannot get Ensures from the chemist and Violet is not eating. Violet indicates that she would go into residential care if there was someone to look after her cat, but this would leave her son homeless. ASC and someone from Parkwood is visiting Violet today. Violet has two care visits a day with one carer, this is no longer adequate, daughter and son advised to tell all this to the social worker. Various calls this day from ASC SW advised to call 999.

On the 14th **ASC** review visit occurred, joint visit with WHG. Concerns raised immediately on visit by Social Worker regarding Violet's health (wound care and possible sepsis). Requested ambulance immediately, which led to admission to hospital and a Safeguarding Contact from WMAS. When Violet presented to the PRH Emergency Department having been brought in by ambulance accompanied by

her daughter. Her arrival was pre-alerted to the department due to her very poor condition. On arrival her initial working diagnosis was sepsis/chest infection. The initial summary note identified she had a history of being unwell with a productive cough along with a history of a fall from her wheelchair 7 days previously. It was identified that she had been symptomatic for 7 days on arrival in ED resus (19.40hrs) it was noted that her daughter was present. It was also noted that Violet was wheelchair bound and had carers at home. A routine skin check within the ED, completed as part of her overall physical examination identified a burn to her left buttock, ED staff were informed by family that this had occurred as a result of carers leaving a hot pack/bag on her back It was also noted that she had another burn to her back and this was identified as having been caused by a hot bottle left on her back by her carers. At this point family had left the department so staff were unable to clarify/verify that information. Violet herself was unable to provide any information about her care or events leading to her presentation. Violet died whist in the Emergency Assessment Area on the 15th. Subsequent cause of death:

1a Bronchopneumonia

2. Atrial fibrillation, CVA

There is no mention of burns being a contributory factor to the cause of death.

S42 Enquiry commenced following notification of death. Violet's support worker is concerned that she is being neglected by the family and carers. There are wounds on Violet that don't quite match with the explanation given by her family. The family say she had burns on her back which were caused by the carers giving her an uncovered hot water bottle. There are no notes on her GP records about any burns, the nurse in resus commented that the wounds do not look like burn wounds. The house is very unclean throughout the property and is not suitable for Violet to live in. Violet herself appears unclean and unkempt; the family say that the carers are not helping her to shower as they should do. Violet has been having trouble with swallowing for a few months; her GP is aware of this. Her family say she has not been eating and drinking as normal for her over the last few days. Violet is very thin in stature. Violet has a wound to her back and a burn to her forehead which is about 3-4 weeks old, from setting her hair alight, this is on her GP records and does look like a burn.

6. Practitioners Event

6.1 A practitioner learning event was held in June 2025. This event involved front line staff and was facilitated by the report author. The purpose of the practitioner event was to provide professionals who had worked with Violet and knew her in that context, to share their insights and identify key areas for learning. The author would like to thank all members that participated for their open and honest approach to learning and understanding that, though distressing, this event was key to shaping learning and not blaming any individual or agency.

6.2 Participants/professionals were asked to consider the circumstances of Violet's death with reference to:

- What went well?
- What could have been done differently?
- How to improve learning?

6.1.3 Concerns expressed by professionals that were voiced at the practitioner event related to Violet's property being in a very poor state (dried cat food, dirt not cleaned correctly). She lived with her son who was a single man. The daughter was known as the main carer (claimed carers allowance).

6.1.4 It was made very clear that Violet did have her voice heard particularly from agencies and she knew her own mind. The hoarding was discussed, and it was agreed it was not a typical hoarding case however more of messy items. There was no attachment to the items and efforts were being made to reduce items.

6.1.5 It was discussed the concerns of housing, and one consideration was whether the housing officers voice was heard or is there an unconscious hierarchy within referrals to ASC and other agencies. It was also considered that a MDT would have been a reasonable consideration towards the end of Violets life.

Recommendation 1: All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.

7. Analysis and Learning

7.1.1 As the report author, the author has attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

7.1.2 Having reviewed the chronologies, and agency reports and listened to the practitioners involved in caring for Violet an analysis for each of the key lines of enquiry identified is outlined below.

7.2 Was appropriate medical attention sought at the relevant times for Violet?

7.2.1 A safeguarding referral was made by the GP on the 17/4/25 due to Violet receiving a superficial burn to the forehead. (111 were contacted the day before by the daughter). When ASC received this referral on the 17/04/24 contact was made

with Violet and her son. An explanation was given for the accident. Violet was ordinarily able to light cigarettes independently; however reduced mobility was the reason for the accident. As a result, the family had increased observations of Violet in relation to smoking. ASC also spoke with the care agency and no concerns were raised. There was an appropriate referral made to the fire service for any further discussion regarding fire risk and safety, with Violet's consent. It was also apparent from the referral and subsequent contact that Violet had accessed the GP with support from family for medical attention in relation to the burn.

7.2.2 On the 23/04/24 when the care agency made a referral to ASC this related to possible neglect by family member (s) in relation failing to contact a GP when required and or attending medical appointments. Subsequent contact with the agency did not identify any specific neglect beyond a concern about family putting a plastic covering over a sore on Violet's leg. Whilst a plastic covering over her leg may not be clinically appropriate it would not indicate abuse in isolation. The only other issue raised by the agency was family failing to access medical appointments. On screening and direction from the Safeguarding Duty Worker, the agency confirmed that all medical appointments were being attended with the GP. As there was not sufficient evidence of abuse or neglect and she was being reviewed clinically this did not progress through the Safeguarding Process. The contact was closed with advice to the referrer/agency to raise any further concerns regarding requiring medical attention to relevant medical professionals.

7.2.3 On the 24/04/24 there was a request from WHG to ASC regarding OT support and equipment which was dealt with effectively by signposting to Moving and Handling and Wheelchair Services.

7.2.4 On the 03/05/24 an urgent review of care was requested and responded to. The referral information also stated that a GP Practice Nurse was involved in dressing for pressure sores and therefore clinical oversight was suggested as being in place at the time of referral. Subsequently when the social worker visited on 14/05/24 it was apparent that medical attention was required, and an ambulance called, and Violet was admitted to hospital.

7.2.5 A S42[1] Enquiry commenced 5/08/24 which concluded that: "Current information would not provide the evidence to up hold the concerns, commutative set of circumstances and her repaid deteriorating health led to her passing, concerns not substantiated." Some of the rationale within the S42 being:

> "It is not clear what the injury was on the back, the social worker thought bruise or burn, daughter thought it was a burn due to carers putting hot water bottle on her back, not noted in the daily logs.
>
> "The care provider had documented the injuries via a body map from 01.04.24 to 06.05.24, and recorded her legs were being treated by district nurse, she was seeing the GP regularly and according to the daughter had been at the GP surgery the previous day, health professionals engaged but hadn't

[1] Care Act 2014

recognised the seriousness of her poor health. There was no record from the notes of an injury to her back but clearly documented the recent incident where she had burned her hair causing injury.

Violets health was significantly deteriorating, this is demonstrated by the increased health care being provided, reading through the case notes and discussing feedback from the allocated social worker it leaves the impression that the family were not coping or had the level of skills to meet their mum's needs or identify the severity of her decline in her health, although her health professionals hadn't either at the time, however further support had been recognised by those around her and a review had just started to take place with this in mind, unfortunately she passed away before any increased support could be put in place."

7.2.6 As far as WHG where aware appropriate medical attention was sought at the relevant times. WHG did notice a decline in Violet following the incident that caused burns. The family were advised as to medical needs but on occasion calls were made independent of family when necessary to the medical practice, Family Connect and emergency services.

7.2.7 Referrals received by the DN team were appropriate and medical attention was sought for Violet, and District Nurses were visiting on a twice weekly basis. Records show that Violet attended a clinic with the podiatry team with her son. The DN team advised the GP when DN team were discharging Violet from the service. All clinical interventions were recorded on the electronic patient record system, RiO. Discharge advice was documented and provided to the GP.

7.3 Was hoarding identified by agencies? If so, what action was taken?

7.3.1 Housing officers from WHG identified hoarding[2] although have stated it that it was not a classic hoarding case (not at the threshold for safeguarding). They have stated it was more an untidy, unhygienic property with large accumulations of clothes and bric-a-brac (this was confirmed also at the practitioner's event). There were some photo's that were taken at the time to show the property condition. The housing officers discussed the concerns with the family.

7.3.2 SCHT electronic notes on 08.03.2024 indicate that there were concerns regarding hoarding, but previous notes do not highlight these concerns. SCHT did not take any action regarding hoarding. The notes do not indicate that the DN's worked together with the member of the WHG enablement support team to identify any further actions. Notes indicate that help was being instigated by the support team, but there was no evidence of further discussions with the family around this. The DN team were aware of support being provided due to a member of the housing group support team being at Violets property. Hoarding concerns were not discussed with the family by SCHT.

7.3.3 Within ASC beyond a brief mention of the condition of property, there is no evidence on the contacts raised that would indicate hoarding at a threshold for

[2] TWSP_Hoarding_Policy___reviewed_Feb_2024_FINAL_v2.pdf

Safeguarding. It is not discussed as a concern in subsequent information gathering with family and partner agencies in relation to Safeguarding Contacts received or the S42 Enquiry. A review of the ASC record and previous Care Act Assessment and Reviews does not identify hoarding being a concern.

7.3.4 The GP had not done a home visit for over 5 years so had no evidence of hoarding.

7.4 Were agencies able to effectively communicate with the Primary Carer?

7.4.1 ASC Safeguarding Contacts indicate that discussions were held in relation to the referrals and that the family engaged in these discussions. Discussions are also recorded in respect of the Safeguarding Contacts with the Primary Care Agency, Prayngel. ASC records indicate contact with the daughter on the previous Care Act Assessments and Reviews. The Safeguarding Contacts indicate discussion with the daughter, and it is apparent that she had a primary role in caring for her mother. The Safeguarding Contacts also indicate discussion with other family members, including son who lived with his mother and had some involvement in provision of care outside of the formal care package. The contacts also reveal discussion with the primary care agency, Prayngel, involved in delivering the package of care to support Mrs Trow.

7.4.2 The GP had the Daughter identified as Violet's main carer recorded in consultation notes. It was the daughter who mainly accompanied Violet to the GP Practice appointments.

7.4.3 WHG communicated with the daughter effectively on a significant number of occasions.

7.4.4 DN Records identify and support communication with the daughter as the primary carer and had discussions around wound dressing for Violet. Appropriate contact was made where there were concerns around wound care, and advice provided around skin care for Violet.

7.5 Were safeguarding concerns identified and dealt with appropriately? Is this clear in the records?

7.5.1 The following Safeguarding Contacts were raised 17/4/24; 23/4/24; 3/5/24. Process was followed appropriately and screened by the Safeguarding Duty Worker within 24 hours, including lateral checks with family and partner agencies. The Safeguarding Contacts17/4/24 and 23/4/24 did not progress further and the rationale is sound. A contact dated 24/4/24 requesting a review of support was screened by Family Connect the same day, including lateral checks with the referrer, with the outcome of advice, information and signposting to appropriate Moving, Handling and Wheelchair Services. The Safeguarding Contact dated 3/5/24 was reviewed by the Safeguarding Duty Worker the same day and assigned to ASC locality team for urgent Care Act Review to explore change in needs in view of the request for increased support due to deteriorating health and family struggling to meet needs. A review commenced with the visit on 14/5/24. The response of the Social Worker who

attended indicates that the health concerns were recognised and responded to immediately. A Safeguarding Contact was raised that day by the ambulance crew attending. Following Violet's passing, a proportionate S42 Enquiry was commenced in response to the WMAS contact raised leading to admission to hospital.

7.5.2 The GP made 2 referrals to safeguarding. The practice would have liked to receive information from family connect regarding the referral as they did not hear anything back from Family Connect.

7.5.3 WHG were aware of the referral made by the GP and submitted their own referral on 03/05/24. They followed this up with ASC on the 8th and 10th and also contacted the GP on the 09/05/24. This demonstrated WHG had clearly identified safeguarding concerns and were proactive in seeking further support following their initial referral.

7.5.4 Safeguarding concerns were shared with SaTH ED staff by the Ambulance crew who transported Violet to ED. ED staff were aware and concerns documented however at the time of presentation the immediate priority was her clinical care. The ED staff took appropriate action; however, they did not immediately share information with the Trust safeguarding team although they did complete a Datix (incident report). The Trust safeguarding team liaised with the medical examiner to make them aware of an open safeguarding along with updating the LA safeguarding teams. The Trust Medical Examiner was informed of the concerns shared by the Ambulance crew.

7.6 Was Violet's voice heard? Was Violet able to share concerns of her own?

7.6.1 A discussion was had with Violet by the Safeguarding Duty Worker in relation to the Safeguarding Contact dated 17/4/24. In the main conversations were with the daughter as advocate. The record did not indicate that Violet lacked capacity. It would seem Violet would have the ability to raise a concern to an extent to carers who attended daily and would have the opportunity to do so. It is likely she would need support to raise a formal referral for Safeguarding or Health concerns in view of her support needs. The ASC records suggests attempts were made to discuss with Violet on the visit for the Care Act Review on 14/5/24 but this would be difficult due to her pain and presenting health needs. Furthermore, the immediate requirement was access to appropriate health services at that time, which was actioned.

7.6.2 Violet was very clear about her wishes regarding her living arrangement which she often expressed to the Practice Nurse. Violet gave very clear verbal answers and facial expressions to match what she was saying and hearing. The daughter was almost always present at GP appointments; the son was present at some of these also.

7.6.3 Violet disclosed on her last appointment at the Practice that she would go into residential care if there was someone to look after her cat, but that this would leave her son homeless. Social Services and someone from Parkwood were due to visit

her later that day. During the practitioner event it was confirmed on a number of occasions to Violet that her son would not be made homeless.

7.6.4 WHG were able to report when conducting works in the property Violets thoughts were taken into account, also when discussing a potential move to more suitable accommodation. Violet's voice is detailed in their case notes. However, there was never really the opportunity to speak with Violet totally alone although there were conversations when Violet was in one room and the daughter was in another. The impression created was that Violet was very much in charge. Violet never raised any concerns of her own and was very adamant and forthright in her views.

7.6.5 DN had some evidence of hearing the voice of Violet. Violet stated to the podiatrist that she *'only drinks black coffee'*, and on 06/02/2024 stated that she was *'eating and drinking well'*. It is not evident from the records that Violet raised concerns of her own. Violet was spoken to alone away from primary carers, and the notes demonstrate that discussions were held, and advice provided around skin care, diet and fluids.

8. Conclusions & Good Practice Identified

8.1 The GP practice had already identified and completed learning prior to submission of their IMR which included.

- All safeguarding referrals are sent from the practice's main email address.
- All Practice staff are aware of the Safeguarding Policy and are encouraged to review this at regular intervals. It forms part of the staff induction policy.
- To ensure continuity for when a person is on leave or unable to access emails.
- To analyse 111 reports in each individual case especially if receiving two in a short space of time. i.e. contacting the patient to advise to either go to A&E or attend the practice if they refuse.
- Staff are aware of any safeguarding patients who we need to follow up if they DNA appointments.
- Unable to follow up safeguarding patients who cancel their
- appointments online. Their own online digital strategy is encouraging
- patients to use on line facilities, and they are aware this limits inputs for
- intervention from the practice if they cancel online. As a result, this has
- been raised as a national issue. There is no policy for adult not brought to appointment - there is a code for adult not brought to appointment which is not consistently used. All staff have been instructed to use the code adult not brought to appointment but also to telephone all patients who do not attend appointments.
- There is a combined vulnerable adult and safeguarding patient list, but this does not consider those patients who are vulnerable with no safeguarding concerns. Patients are seen at least annually. If a patient

is overdue a review and they request medication, they will call the patient in for a review appointment. There care plan advanced planning wishes and carer status is discussed at this appointment.

8.2 The involvement of WHG was primarily to deal with the property condition which involved close working with the family (son and daughter) of Violet who needed both support and guidance to take the most appropriate actions to support Violet. However, this review found that WHG involvement went far beyond just the condition of the property. Contact was made with the medical practice to arrange an appointment and to attend with the family to support them in articulating Violet's circumstances. There was the request made for a suitable bed to assist Violet due to mobility and conversations with the DN to share concerns as well as a request to ASC for more support and a safeguarding referral. WHG also chased up referrals which is good practice and those involved should be commended for their proactive approach.

8.3 The learning for WHG and all agencies is to be more pro-active in seeking MDT meetings to satisfy themselves that the concerns were being dealt with appropriately that they had raised. A number of services were involved with Violet and a MDT forum would have been appropriate.

8.4 When concerns were raised and chased up the panel believe that all agencies need to better understand their own escalation policies, so it is very clear to all staff how to escalate concerns beyond their initial referrals. The Board are aware of the constant need to complete the feedback loop between agencies. This is already an area of focus within ASC (mirroring the findings from the recent children's JTAI) with an addition mechanism being built in to catch any referrals which still required feedback in a timely manner.

8.5 SCHT have identified additional learning around professional curiosity, and have subsequently produced a learning briefing with a focus on this, and a short video has been created around the key areas of professional curiosity, that has been cascaded to all clinical staff and teams, and raised in both adults and children's operational groups. A newsletter was also published in September 2024 with a focus around professional curiosity. All resources are also available to staff via SCHT's intranet on 'Staff Zone'.

8.6 The panel have considered whether the WHG referral on 3/5/24 was given the appropriate response. Fundamentally the panel have considered all referrals have to be appropriately dealt with in a timely manner. Violet was seeing healthcare professionals frequently at this point. When ASC did attend and WHG were also in attendance an ambulance was called as that was the primary need for Violet at that point. Tragically shortly after this point Violet sadly passed. The panel are also conscious of hindsight bias as reflected in this report and believe the response by ASC given what was known at the time was appropriate. The panel are also content from discussions that there is no hierarchy in referrals and each agencies referral are

assessed regardless of who the referrer is. The panel where pleased to hear that housing is a very common referrer to ASC.

8.7 The panel would also like to recognise the proactive nature of agencies who had identified their own learning and taken action prior to the submission of IMR's. This is good practice.

8.8 The safeguarding lead from the care agency has spoken with the chair and expressed concerns around the care package being only once in the morning and once on an evening, thus a long gap between visits. Also, that careers did raise concerns about attendance of GP appointments with family but subsequently found out they did not attend. They did raise safeguarding concerns. They had already identified learning regarding the escalation process in their own agency and multi-agency sharing which are both recommendations of this review and the care agency should be included in the action plan.

9. Recommendations

Recommendation 1. All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.
Recommendation 2. All agencies involved to ensure all staff are aware of escalation policies in their own agencies and utilise appropriately and also be aware that local authorities have their own escalation processes, should practitioners not agree with a decision that has been made.