# Board publishes review into death of elderly woman

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Wolverhampton Safeguarding Adults Board has today (Friday 9 August, 2019) published the findings of a Safeguarding Adult Review into the death of an elderly woman.

The woman, referred to in the review as Edith, passed away in hospital last summer at the age of 80. She died from sepsis, community-acquired pneumonia and frailty old age, but enquiries carried out after her death found that her elderly nephew, whom she had been living with for the previous eight years, had been struggling to meet her personal care needs in the months up until she passed away.

Safeguarding concerns around possible neglect or self-neglect had been raised in 2017 when Edith had previously been admitted to hospital. She had subsequently been discharged home with a high level of home care support, but this was ended at Edith's request in February 2018.

Wolverhampton Safeguarding Adults Board commissioned the Safeguarding Adult Review to ascertain the involvement of agencies with Edith in the lead up to her death, and to determine if anything could be learned which may improve frontline practice in the future.

The report published today, by independent author Chris Brabbs, identifies a number of learning points and makes seven multi-agency recommendations to Wolverhampton Safeguarding Adults Board. These include what professionals should do in instances where neglect or self-neglect may be putting a service user at risk, but where assessments or services have been refused or prevented, and around the sharing of information.

Linda Sanders, Independent Chair of Wolverhampton Safeguarding Adults Board, said: "This is a very sad case in which an elderly woman was no longer able to look after herself and, for whatever reason, declined long-term health and social care support.

"She was a widow and did not have any children, and instead relied upon her extended family to meet her significant care and support. However, they had their own difficulties and it is clear from the review that her nephew and others were struggling to meet her needs.

"The review looked in forensic detail at the involvement of a range of agencies with Edith in the 12 months before her death.

“It identified a number of areas where professionals demonstrated good practice – including the clinical care provided by health professionals in hospital and in the community, the initial assessment of Edith’s support needs and the attentiveness of her home carers.

“It also identifies a number of learning points and recommends seven actions which are being implemented by Wolverhampton Safeguarding Adults Board and the individual agencies concerned.

“Ultimately, a key recurring issue throughout this case was the difficulty that professionals had in getting the necessary level of engagement with Edith to be confident that her wishes and feelings about her care had been fully explored - including whether it was her decision to refuse care or not.

“Not only does this highlight the importance of always hearing the voice of service users, as well as their families, but it also demonstrates the challenge that professionals face in balancing a person’s right to make what appear to be unwise decisions for themselves with their duty to keep people safe. In Edith's case, this was not achieved, with too much weight instead placed on her autonomy.

“The review makes a number of recommendations in respect of these issues, and also recommends exploring further the use of care passports through which to share information about service users whenever they present in any health, hospital or care setting, and which in this case would have painted a much fuller picture of Edith’s circumstances to the professionals who worked with her.”

The Safeguarding Adult Review’s recommendations have been accepted by Wolverhampton Safeguarding Adults Board which is monitoring their implementation.

Agencies involved in the Safeguarding Adult Review included the City of Wolverhampton Council, the Royal Wolverhampton NHS Trust, the University Hospitals Birmingham NHS Foundation Trust (Queen Elizabeth Hospital), Wolverhampton Clinical Commissioning Group, West Midlands Police, West Midlands Ambulance Service, Woodford Home Care and Wolverhampton Homes.

The Safeguarding Adult Review report has been published on the Wolverhampton Safeguarding Adults Board website. For more information, please visit www.wolverhamptonsafeguarding.org.uk/safeguarding-adults/safeguarding-adults-board.

**ENDS**

**Note to editors:**

1/ A Safeguarding Adult Review is a multi-agency review process which seeks to establish the circumstances around an individual's death and determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame; it is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

2/ Section 44 of the Care Act 2014 requires a SAR to be carried out “where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board’s area has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult”.

3/ Wolverhampton Safeguarding Adults Board provides strategic leadership for adult safeguarding work to ensure there is a consistently high standard of professional response to situations where there is actual or suspected harm. For more information, please visit www.wolverhamptonsafeguarding.org.uk/safeguarding-adults/safeguarding-adults-board.