Northamptonshire Safeguarding Adults Board

Safeguarding Adults Review

SAR 059 – Adult H

Report Author: Sarah Morris; Chief Principal Social Worker, North Northants Council

Date agreed by NSAB: 03.11.2026

1. Introduction

A Safeguarding Adult Review (SAR) referral was submitted to Northamptonshire Safeguarding Adults Board (NSAB) from East Midlands Ambulance Service in May 2024. The referral raised concerns regarding Adult H's death and the possible failure of agencies to support. The referral was considered at the NSAB SAR Subgroup and the Chair and statutory partners agreed with the recommendation that the referral met the criteria for a Safeguarding Adult Review (SAR) under s44(2) of the Care Act 2014.

2. Safeguarding Adult Reviews (SAR) - Legal Context & Purpose

2.1 Section 44 of the Care Act 2014 requires Safeguarding Adult Boards to carry out safeguarding adult reviews 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

(2) 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 of neglect before the adult died)

(3) Condition 2 is met if

a) the adult is still alive and

b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other 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).

2.2 A SAR is a supportive multi-agency review process for partner agencies to look at agency contact and practice and identify lessons that can be learned from complex or serious adult safeguarding cases where an adult at risk has died or been seriously harmed, and abuse or neglect has been suspected. The review will not re-investigate or apportion blame, but aims to identify gaps in process and practice, including where agencies could have worked better together, and to recognise any good practice. Recommendations are made to change and improve practice and services.

2.3 The review process necessitates openness and critical analysis to allow an exploration of the decisions made and actions taken to identify any lessons to be learnt to improve practice from the circumstances, and to apply those lessons to future cases.

2.4 All agencies involved with Adult H were required to contribute to the review and a scoping of information from all known agencies involved was requested. Adult H was known to the following agencies/services: Age UK, Department of Work and Pensions, Derbyshire Health United (DHU), East Midlands Ambulance Service, Northampton General Hospital, Northamptonshire Healthcare NHS Foundation Trust (NHFT), Northamptonshire Police, Penvale Park Medical Centre, Northamptonshire Probation Service, and West Northamptonshire Adult Social Care.

2.5 A desktop review was the agreed methodology used as the most proportionate way to approach the review. All agencies involved in the SAR provided a chronology to enable the author to review key aspects leading to the incident. The SAR was approved in August 2024, but the start was delayed due to the number of ongoing SARs and a lack of capacity within the partnership and the NSAB Business Office to complete. The case was discussed at SAR Subgroup again in July 2025 where NHFT agreed to review learning for the organisation. Following NHFT's review, the case was discussed again at SAR Subgroup in October 2025 where members felt there was additional learning and that the desktop review should continue.

2.6 The agreed scope of the SAR was 13th November 2023 to 13th May 2024.

This report summarises the key findings from the review. The main key lines of enquiry in the audit were:

- Were there missed opportunities to support Adult H further following the visits from phlebotomists DHU Out of Hours service on 3rd April 2024?
- Could/should more be done to support colleagues such as Age UK workers to spot the signs of someone's decline in physical health?

3. Who was Adult H?

3.1 Adult H was a 79-year-old white British man.

3.2 Adult H had a history of kidney disease and diabetes. He had been known to Haematology since 2005 for Thrombocythemia. He lived on the ground floor of his house. He had a weekly cleaner from Age UK, and she advised that Adult H was able to cook for himself.

3.3 We understand Adult H had a sister with whom he was in touch, and children with whom he wasn't. He had worked for an airline and had model airplanes and photos of airplanes within his house. He enjoyed watching television, particularly detective shows.

4. NSAB Contact with Adult H's Family

4.1 NSAB has been unable to identify any contact details for Adult H's family and so it has not been possible to discuss this SAR with them or share the draft report.

5. Chronology of events during the scoping period 13th November 2024 to 13th May 2024

5.1 **1st December 2023** – Adult H was removed from the podiatry care plan during December 2023 as there had been no contact with him over the last three years and he was considered to be a low-risk patient. This was because Adult H had not responded to requests to attend appointments.

5.2 **27th March 2024** – Referral from Haematology Department to Penvale Park Medical Practice for a phlebotomist[1] visit to take bloods.

5.3 **3rd April 2024** –A phlebotomist visited Adult H to take his bloods. Adult H reported that he was feeling fine.

5.4 **3rd April 2024** – Out of Hours (OoH) undertook a welfare visit in the evening, due to the blood test having identified that Adult H had high potassium levels that required follow up. The house was described by OoH as being in darkness. Adult H came to the door with a Zimmer frame. OoH staff explained about the high potassium levels and advised that he should attend A&E; Adult H declined and understood he could become very unwell. Adult H thanked them for their visit and explained that he wasn't able to answer the phone as he was in bed and unable to get up to answer the phone. OoH staff offered a hospital admission for a second time, but Adult H declined to attend. He was deemed to have full mental capacity. A report was uploaded to the patient record but there was nothing in tasks to follow up from this. *We have been advised that OoH/DHU informs the GP of night visits to every patient they visit.*

5.5 **16th April 2024** – Haematology rang Adult H for a telephone appointment but got no answer. The registrar documented that another appointment would be made for 6 weeks and a blood test requested before that.

5.6 **13th May 2024** – The cleaner from Age UK was unable to gain access to the property so contacted her supervisor. The supervisor contacted Adult H's next-door neighbour who also could not gain access and so contacted the emergency services.

5.7 **13th May 2024** – The police gained access, found Adult H very unwell and called East Midlands Ambulance Service (EMAS). EMAS transferred Adult H to hospital and described him as 'unresponsive, emaciated, and unkempt. He had extremely low levels of oxygen in his blood.'

[1] A phlebotomist is a specialised allied health professional whose primary role is to collect and process blood samples.

5.8 **14th May 2024** – Adult H died in Northampton General Hospital. Cause of death was (1) Pneumonia, (2) Malnutrition, dehydration, emaciation.

6. Key lines of enquiry findings

This section explores the findings from the chronology and discussions with colleagues from Northamptonshire ICB, the GP surgery, and Age UK.

6.1 Observation and professional curiosity

6.1.1 Adult H had been receiving a cleaning service from Age UK since 2022 with a worker visiting every week. Given that Adult H's cause of death was pneumonia, malnutrition, dehydration and emaciation, his physical health will have deteriorated over a period of time. Had the Age UK worker reported this to their manager, Age UK could have referred to Adult Social Care, and agencies could have worked with Adult H to consider the risks he was facing and also his strengths and wishes.

6.1.2 It is not apparent from the Phlebotomist records as to what they observed when visiting Adult H to take bloods on 3rd April 2024. It should be noted that the role of a Phlebotomist is to take bloods, they do not assess a patient's general health. The police who attended on 13th May 2024 reported that 'further care was clearly needed on a daily basis'. Had this been identified on 3rd April 2024 a referral could have been made to Adult Social Care if Adult H was felt to be at risk of self-neglect. Feedback from the GP practice is that they would have expected the adult to have looked unwell at this point. However, the cleaner from Age UK said that she saw no deterioration in Adult H's physical health over the time she visited him.

6.2 Follow up on Adult H's lack of response to contacts

6.2.1 GP records record him as being 'housebound'. During July 2023 (outside of scoping period) there were four attempts to contact him without success. In December 2023, Adult H was removed from the podiatry care plan. The chronology from the GP practice recorded that he was deemed as a low-risk patient and that this was because he had not responded to requests to attend appointments. The lack of response to invites to appointments should have been seen as a risk factor. There was an opportunity to consider how to engage with someone who had a number of physical health issues and was finding it difficult to engage with services. Had this been more clearly detailed within the practice records as it became apparent that he'd not responded on a number of occasions, it would have been clearer to colleagues going to visit Adult H out of hours.

6.3 Out of Hours visit

6.3.1 The Out of Hours (DHU) nurse visited Adult H on the evening of 3rd April 2024 to undertake a welfare visit as Adult H had not responded to a call to talk to him about concerns about high potassium levels identified by his blood test. DHU explained that no one entered the house as they were only there to deliver the test results and recommend a hospital admission. However, given the concerns about the risks to Adult H's physical health and the fact that he was declining a hospital admission, this was a lost opportunity to use professional curiosity and to build a relationship with him to discuss the concerns.

6.4 Mental Capacity Assessment

6.4.1 The Out of Hours worker recorded that Adult H "has full mental capacity - to call back SOS if any concerns, breathless, chest pain, otherwise will review with own nurses/GP as needed." It is not apparent whether the Out of Hours nurse was aware of, or took into account, the history of Adult H not contacting or responding to Health services - Out of Hours colleagues had access to the GP records and so would have been able to see that the surgery had been unable to contact him by telephone.

6.5 Follow Up following Out of Hours visit

6.5.1 Colleagues from the Haematology Department have confirmed that Adult H was given a telephone consultation on 16th April 2024 (this was probably in response to the abnormal blood test results being flagged by the laboratory) but he could not be contacted. The registrar had documented that another consultation would be made for 6 weeks' time with another blood test before then. Again, there was no consideration of the history of Adult H not responding to invitations. The Out of Hours nurse had highlighted to Adult H the risks that he faced; however, the concerns about his physical health were not

followed up. The Out of Hours team did not ask the GP to forward their report on to the Haematology Department. Had they done so, the Haematology Department would have been aware of Adult H's inability to get to the telephone. The report from the Out of Hours team was received by the GP surgery but not followed up. Whilst Adult H was under the specialist care of the Haematology Department, this was an opportunity for the surgery to follow up on someone who had declined a hospital admission, against medical advice.

7. Good Practice

7.1 The Age UK cleaner contacted their manager when unable to gain access on 13th May 2024 and this led to emergency services undertaking a welfare check and finding Adult H.

8. Missed Opportunities

8.1 The weekly visits by Age UK cleaners were a missed opportunity to identify Adult H's deteriorating physical health and need for care and support. The cleaner described Adult H as someone who was able to cook for himself, and stated that whilst he could look after himself, it appeared as though he hadn't washed himself or his clothes recently, however, this was not to the extent that she felt he needed support with this matter. She did not feel that his physical condition had deteriorated towards the end of his life, although advice from health professionals is that, given his cause of death, there would have been a physical deterioration.

8.2 There was a missed opportunity to understand and share the fact that Adult H was not responding to contact from his GP practice. Sharing this information would have meant that it could have been taken into account in the mitigation planning by the Out of Hours worker and in the follow up from the Haematology Department, either of which might have led to a more proactive approach to engaging with Adult H and discussing the concerns.

8.3 If Adult H's health was in decline, the visit by the Out of Hours staff on 3rd April 2024 could be seen as a missed opportunity to use professional curiosity and escalate concerns and risks. Referrals could have been made to Adult Social Care to consider support.

8.4 There was a missed opportunity to follow up on the concern that Adult H's potassium levels were not in normal ranges, and he was declining the medical attention advised. This would have also allowed greater consideration of his mental capacity to do so.

9. Agency learning and what has changed since the incident

9.1 Since Adult H's death, Age UK has provided training for staff on safeguarding.

9.2 The GP Practice was taken over by a new provider in April 2024. They would now reach out to any patient who does not attend more than three appointments in six months, to understand why.

10. Local and Second National Safeguarding Adult Review Analysis 2024

10.1 In Northamptonshire, of the 34 SAR referrals received in the last two years (1st April 2023 – 31st March 2025), 21 (61%), referenced elements of self-neglect. This is in line with the findings in the national SAR analysis:

- 60% of the cases reviewed as part of the 2nd National SAR Analysis found self-neglect to be the highest abuse type. 46% of the SARs reviewed related to individuals with substance dependency, 13% featured homelessness and 72% of individuals were reported to have mental ill health.
- 72% of the SARs reviewed identified that inter-agency case co-ordination and working together remain the greatest challenge. The identification of risk/management of risk feature in 82% of the SARs reviewed, and in 56% of cases, it was found that there was poor recognition of the abuse or neglect.

- Many of the SARs reviewed identified issues with how agencies failed to engage with individuals and how professionals failed to understand a person's history with a view to overcoming barriers. There was a failure to identify repeated patterns of engagement followed by disengagement, and a lack of professional curiosity to explore what might be happening 'beneath the surface.' There was also a focus upon what was presented rather than what was not. In terms of safeguarding and missed opportunities, the 2nd National SAR Analysis found that alcohol dependency, neglect of health care and self-harm were not recognised as forms of self-neglect that warranted a safeguarding referral.

11. Analysis

11.1 Health records detailed that Adult H had not responded to calls from the GP Practice, Podiatry, and finally, Haematology. Whilst this was recorded, there was no analysis of the risks around this or recommendations as to how colleagues should engage with Adult H in the future and ensure that his health needs were addressed. The Out of Hours staff who met with Adult H were aware of the fact that he could not easily answer his phone, however, this information does not appear to have been shared with the Haematology Department, who used solely that method of contact to try and follow up on the concerns. There were no steps taken to understand whether Adult H would like support to get a new phone socket put in beside his bed.

11.2 EMAS colleagues attending Adult H on 13th May 2024 considered that his condition must have been on-going for weeks or months, describing him as very thin and underweight. The representative from the GP Practice spoken with agreed that this would have been the case. There is no record that there was any concern about this when the Phlebotomist and then Out of Hours nurse visited on 3rd April 2024, however, it seems likely that Adult H was not eating well at this time, given that his causes of death included emaciation. Adult H would have been seen by the cleaner from Age UK in the period between 3rd April 2024 and 13th May 2024, but his deteriorating physical health was not picked up by them and therefore not reported to Health or Social Care.

11.3 When Adult H declined an admission to hospital on 3rd April 2024, the Out of Hours nurse recorded that he had capacity and understood the risk of becoming very unwell or dying. This was based upon a conversation on the doorstep and there was no formal capacity assessment undertaken or recorded. Given Adult H's history of difficulties in engaging with Health, it would have been useful to have highlighted this so that his mental capacity in this area could have been considered more formally by his GP and the Haematology Department. The mitigation to the risk is recorded as being that Adult H would call back if he experienced any chest pain or breathlessness; there was no exploration or further conversation by the GP as to whether he would really do this and the history detailed in his GP's notes suggested that he probably would not – this is important given Adult H's history of disengagement with services.

12. Recommendations

The following recommendations are unique to this case.

All recommendations should be actioned and completed within six months of publication other than where stated. When considering the recommendations and the action needed to be taken, agencies should consider what metrics could be utilised to provide evidence of positive change. Metrics might include benchmarks and key performance indicators (KPIs), audit findings, additional training provided and the number of staff trained, number of team meetings where new policies and guidance have been shared including the number of staff. Case studies evidencing good working practices are always welcomed. This information would provide an additional level of assurance, not only for the agency, but for NSAB.

1. Age UK to confirm that they continue to provide safeguarding training (including training on self-neglect) to all members of staff working with the public to support the identification of someone's health deterioration and/or ability to care for themselves. The effectiveness of the training should be reviewed periodically.

2. The ICB should provide guidance to GP practices on the importance of reviewing patient's ability to contact/respond to the GP surgery. For example, it was known that Adult H struggled to get to the telephone due to his poor mobility. Therefore, there should be clearly recorded action plans in place, detailing how best to contact and engage with patients who find it difficult to contact / respond to Health services. The impact of the guidance should be reviewed by way of audit and the results shared with NSAB.

3. The ICB should provide guidance to GP practices on the importance of sharing any information received about a patient which would positively influence the care that another department could provide. For example, the concerns regarding Adult H declining to go to hospital despite the risks to his health, and the fact that he struggled to get to the phone. Again, this action should be reviewed after 6 months to evidence whether or not the guidance has been helpful to practice.

QR Code and useful links to the NSAB website, policies, procedures, and guidance:

Useful links to NSAB policies, procedures, and guidance below:

Adult Risk Management (ARM) Toolkit

Bite sized learning videos – Professional curiosity and self-neglect

Professional curiosity practitioner guide

Self-neglect guidance

Northamptonshire Safeguarding Adults Board

One Angel Square, Northampton, NN1 1ED

T: 01604 527383

E: NSAB@westnorthants.gov.uk

W: www.northamptonshiresab.org.uk