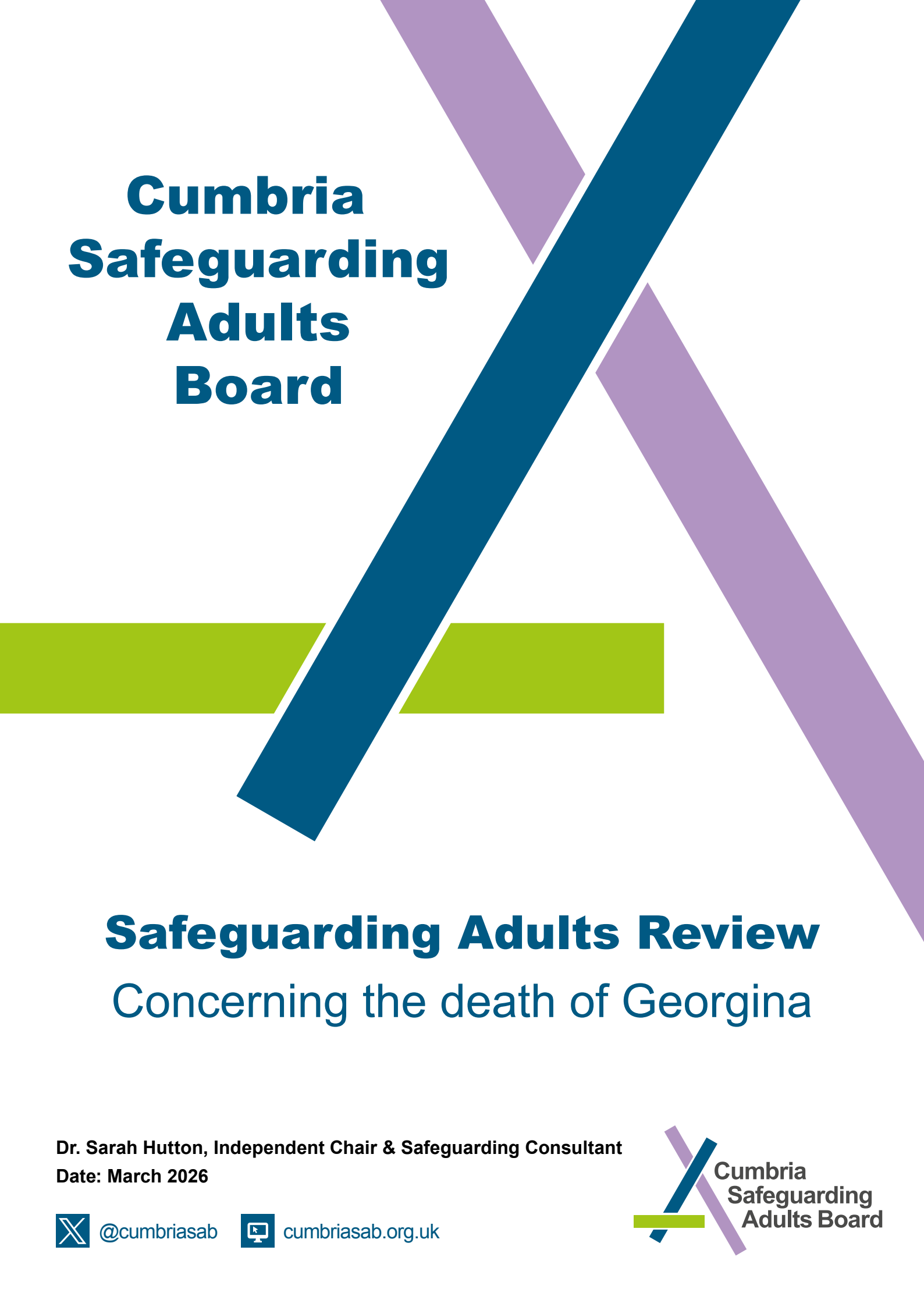




Cumbria Safeguarding Adults Board

Safeguarding Adults Review Concerning the death of Georgina

Dr. Sarah Hutton, Independent Chair & Safeguarding Consultant

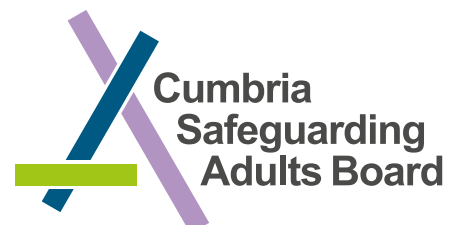
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Cumbria Safeguarding Adult Review

Concerning the death of Georgina

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1. Introduction

This Safeguarding Adults Review (SAR) has been commissioned by the Cumbria Safeguarding Adults Board in accordance with Section 44 of the Care Act 2014¹. The statutory duty to undertake a SAR arises where an adult with care and support needs has died, and there is reasonable cause for concern about how partner agencies worked together to safeguard them.

This Review considers the circumstances surrounding the care and support provided to Georgina (a pseudonym), an 85-year-old woman with complex health needs including dementia, frailty, and reduced mobility, who died in November 2024. The Review focuses primarily on the period from September to November 2024, when concerns regarding her physical deterioration, pressure care, and the sustainability of care arrangements became increasingly evident. Earlier events have been drawn upon where necessary to understand the context and progression of risk.

The purpose of this Review is to examine the multi-agency response to Georgina's needs and to identify learning that can inform future safeguarding practice. In doing so, the Review considers how concerns were recognised, understood, and responded to by the agencies involved, including the extent to which risks were appropriately assessed, communicated, and escalated.

In line with the Terms of Reference, particular attention is given to:

- the recognition and response to escalating risks, particularly in relation to pressure care;
- the identification and support of family carers, including the impact of carer strain;
- multi-agency working, including information sharing, coordination, and escalation;
- the application of relevant policy and practice guidance.

This Review also considers learning from previous Safeguarding Adults Reviews, both locally within Cumbria and nationally, particularly in relation to recurring themes such as carer strain, coordination of care, and escalation of risk. It examines the extent to which this learning is reflected in practice within this case. Throughout, the Review seeks to provide a clear and balanced account of what happened, recognising both areas of effective practice and opportunities for development, with a focus on supporting improvement across the safeguarding system.

It is important that this Review recognises Georgina not solely through the lens of her care needs or the circumstances of her death, but as a person with a history, relationships, and preferences that shaped her experience. Her identity, her environment, and her relationships; particularly with her family, form an important context for understanding both the challenges faced and the responses provided during the period under review.

2. About Georgina

Georgina was an 85-year-old woman who had lived for many years on a rural farm in Cumbria. She had previously worked with horses and maintained a strong connection to her home environment, which remained central to her identity and sense of independence throughout her later life. She was described as a private individual who valued familiarity, routine, and remaining within her own surroundings. Georgina had a complex medical history, including dementia, frailty, reduced mobility, and a number of long-term health conditions.

¹ Care Act 2014, s.44 (Safeguarding Adults Reviews). Statutory duty/criteria for SABs to commission SARs. Home: legislation.gov.uk. [Care Act 2014](#)

Over time, she became increasingly reliant on support for her day-to-day care needs. By 2024, her mobility had significantly reduced, and she required assistance with personal care and daily living activities.

A significant change in Georgina's circumstances occurred following the death of her husband earlier in 2024. This bereavement appears to have had a notable impact on both her emotional wellbeing and her overall functioning. Information from services suggests that, in the months that followed, there was a marked deterioration in her physical health, mobility, and cognitive presentation. This period also coincided with increasing care needs and a growing reliance on others for support. She remained living at home during this time, supported by a combination of family care and formal care provision. Her daughter played a central role in her care, alongside commissioned carers who attended the property twice daily. The home environment was relatively isolated, which at times presented practical challenges in relation to access, communication, and service delivery.

As Georgina's needs increased, so too did the complexity of her care. This included the management of mobility, nutrition, personal care, and, later, concerns relating to skin integrity and pressure care. Those involved in Georgina's care described a situation that changed rapidly over a short period of time. In particular, the weeks leading up to her hospital admission in October 2024 were characterised by a significant decline in her physical condition and increasing concerns from both family members and professionals about the adequacy and sustainability of care arrangements. Georgina was admitted to hospital in October 2024 and was subsequently discharged to a care home, where she remained until her death in November 2024.

3. Methodology

3.1. Purpose

The purpose of this Safeguarding Adults Review is to understand how agencies worked together to support and safeguard Georgina, and to identify learning to strengthen future practice.

In line with Section 44 of the Care Act 2014, the Review focuses on:

- how risks were recognised and responded to as Georgina's needs escalated
- how information was shared, understood, and acted upon across agencies
- how decisions were made in the context of increasing complexity and uncertainty
- what helped and hindered effective multi-agency working

The Review does not seek to apportion blame. Its focus is on understanding practice within context and identifying opportunities for system learning and improvement.

Particular attention is given to the period immediately preceding Georgina's hospital admission, including the management of pressure care, the sustainability of care at home, and support to family carers.

3.2 Approach

The Review has been conducted using a systems-based methodology², drawing on:

- agency chronologies and Individual Management Reviews
- health and care records
- multi-agency practitioner discussion and reflection
- relevant research and national policy guidance

This approach recognises that practice is shaped by the interaction between individuals, organisations, and wider system conditions. The Review therefore focuses on understanding not only what happened, but how and why practice unfolded as it did.

Analysis considers:

- how risk was interpreted at different points in time
- how responsibility for coordination and escalation was understood and enacted
- how professionals worked across the interface between family care and formal services
- how system conditions (including workload, access to services, and rurality) influenced decision-making

To support this, the Review is structured around Key Practice Episodes (KPEs), which focus on critical moments where risks emerged, escalated, or decisions were required. This enables a move beyond chronology to a more analytical understanding of practice.

3.3 Scope of the Review

The Review focuses on the period from **September to November 2024**, when Georgina's condition deteriorated rapidly and care needs became increasingly complex. Earlier events have been considered where necessary to understand the trajectory of her needs, including the impact of bereavement and increasing reliance on both family and formal care. The Review also considers the final stage of Georgina's care, including hospital admission, discharge, and end-of-life support, to understand how decisions were made and care was coordinated.

Family members were offered the opportunity to contribute to the Review. While no direct contribution was received, their perspectives have been drawn from agency records where available.

4. Key Practice Episodes (KPEs)

To support a structured understanding of Georgina's care, the Review has been organised into a series of Key Practice Episodes (KPEs). These represent significant points in time where risks emerged, escalated, or where important decisions were made. The use of KPEs enables the Review to move beyond a purely chronological account and instead focus on the critical moments in Georgina's care, where opportunities existed to recognise, interpret, and respond to risk. Each episode brings together relevant information from across agencies and considers how practice unfolded within the context of increasing complexity.

¹ SCIE (2026) Learning Together (systems approach and analytic tools for case reviews). [Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE](#)

Taken together, the KPEs provide a narrative of Georgina's care journey, highlighting how risks developed and how responses were shaped by the interaction between professional services, family care, and wider system factors:

Table 1 Summary of Key Practice Episodes

KPE	Time Period	Focus	Summary of Issues
KPE 1	Early September 2024	Early changes in Georgina's mobility and care needs	Georgina begins to experience reduced mobility and increasing reliance on others for care. Early signs of pressure damage emerge, with care continuing within existing arrangements at home.
KPE 2	Mid–Late September 2024	Increasing concerns about Georgina's physical condition	Georgina's condition deteriorates over a short period, with growing concerns from both carers and family. Her needs become more complex, particularly in relation to pressure care and mobility.
KPE 3	Late September 2024	Safeguarding concerns and opportunities for wider understanding	A safeguarding concern is raised in relation to wound care. While action is taken, the broader context of Georgina's situation, including carer strain and the increasing complexity of her needs, is not fully brought together.
KPE 4	Late September – Early October 2024	Escalation of need and hospital admission	Georgina's care needs reach a point where they can no longer be safely managed at home. She is admitted to hospital following significant deterioration.
KPE 5	October – November 2024	Transition in care and end-of-life support	Georgina is discharged to a care setting where she receives end-of-life care. Despite ongoing family complexities, there is evidence of compassionate care and support during her final days.

4.1 Understanding the Pattern of Georgina's Experience

Taken together, the Key Practice Episodes describe a situation in which Georgina's needs changed significantly over a relatively short period of time. While each episode reflects specific events or decisions, when viewed collectively they illustrate a broader pattern of increasing complexity, uncertainty, and pressure on those involved in her care.

This included:

- a gradual but accelerating deterioration in Georgina's physical condition
- increasing reliance on both family and formal care
- growing challenges in managing care safely within the home environment
- and a context in which multiple services were involved at different points in time

What is evident across these episodes is that no single issue, event, or decision fully explains the trajectory of Georgina's care. Rather, her experience was shaped by the interaction of a number

of factors, including her changing health needs, the support available to her family, and the way in which services understood and responded to emerging risks. The following section draws on learning from previous Safeguarding Adults Reviews in Cumbria to provide a wider context for understanding these patterns. This is intended to support reflection on whether the themes identified in this case represent new learning, or whether they reflect issues that have been recognised previously within the local safeguarding system.

Learning from Previous Cumbria Safeguarding Adults Reviews

Previous Safeguarding Adults Reviews undertaken in Cumbria have identified a number of recurring themes relevant to this Review and to the patterns described above, including those involving older adults with complex health and care needs, have identified a number of recurring themes relevant to this Review. In particular, reviews such as SAR Pauline and George highlighted:

- the challenge of **recognising cumulative deterioration as a safeguarding concern**, particularly where decline occurs over time
- the **absence of clear coordination and ownership of risk** in situations involving multiple agencies
- the **need to better understand and respond to the role, capacity, and support needs of family carers**
- **limitations in multi-agency information sharing**, where information is available but not brought together into a shared understanding of risk
- **a tendency for safeguarding responses to be triggered by discrete incidents, rather than emerging patterns of harm**
- and the **importance of maintaining professional curiosity**, particularly where family members appear to be struggling

These themes provide an important context for this Review and are drawn upon in the analysis that follows, enabling consideration of the extent to which learning has been embedded in practice.

5. Findings

The findings presented below draw on agency records, detailed information returns, and multi-agency practitioner reflection. The practitioner learning event provided valuable insight into how professionals understood and responded to Georgina's circumstances in real time, including the challenges, uncertainties, and constraints shaping decision-making.

In line with the Review's purpose, these findings are not considered in isolation. They are explicitly situated within learning from previous Safeguarding Adults Reviews (SARs) undertaken in Cumbria, including those involving older adults, carer strain, national SAR evidence, including thematic analyses and relevant academic and policy literature. This approach enables the Review to move beyond describing what happened in this case, to consider:

- how practice aligns with previously identified learning
- where similar patterns of challenge are recurring
- and what this suggests about the embedding and impact of learning across the system

Importantly, this section also recognises examples of thoughtful, compassionate, and persistent practice identified throughout the Review. Practitioners across agencies demonstrated commitment to supporting Georgina, often in complex and emotionally demanding circumstances. These strengths are highlighted alongside areas for learning to ensure a balanced and constructive account. Consistent with national SAR findings, the issues identified in this case reflect the interaction of multiple factors across professional practice, organisational systems, and the relational context in which care was being provided. Understanding these interactions is key to strengthening future practice.³

5.1 Recognition of Deterioration and Cumulative Risk

Georgina's condition deteriorated significantly over a short period during September 2024. Having previously been mobile with support, she became increasingly immobile and spent prolonged periods in bed. During this time, carers reported emerging concerns regarding skin integrity, initially presenting as areas of redness which progressed rapidly into multiple areas of breakdown. Alongside this, her daughter was managing increasingly complex care needs at home and expressing difficulty in doing so.

There is clear evidence that individual elements of this deterioration were recognised. Concerns were raised, advice was sought, and health services were engaged. However, these issues appear to have been understood primarily as discrete clinical concerns rather than as indicators of a rapidly escalating and high-risk situation. National clinical guidance highlights that pressure damage can develop quickly in individuals with reduced mobility and should be understood as a potential marker of wider deterioration and unmet need⁴. The development of multiple pressure ulcers over a short period is therefore not simply a clinical issue, but a signal that care arrangements may no longer be safe or sufficient.⁵

In Georgina's case, the progression from early skin concerns to significant pressure damage suggests that the seriousness and pace of her deterioration were not fully recognised at an early stage. While actions were taken in response to presenting issues, these were not consistently informed by a holistic understanding of her overall trajectory of decline.

This reflects a wider challenge in recognising cumulative deterioration in older adults, particularly where changes may be attributed to ageing or existing health conditions. Previous Cumbria Safeguarding Adults Reviews have identified similar difficulties in distinguishing between expected decline and escalating risk, and in recognising when a change in presentation should prompt a reassessment of need⁶. In this case, the absence of a shared understanding of Georgina's deteriorating condition meant that the significance of early warning signs was not fully appreciated, limiting the opportunity to respond proportionately as her needs increased.

³ Social Care Institute for Excellence (2020) Safeguarding Adults Reviews: Analysis of SARs April 2017–March 2019; Department of Health and Social Care (2020) Care and Support Statutory Guidance (updated).

⁴ National Institute for Health and Care Excellence (NICE) (2014) Pressure ulcers: prevention and management (CG179).

⁵ Department of Health and Social Care (2018) Pressure ulcers: how to safeguard adults.

⁶ Cumbria Safeguarding Adults Board (2023) Safeguarding Adults Review: Pauline and George; Cumbria Safeguarding Adults Board (2024) Safeguarding Adults Review: Sarah.

5.2 Coordination, Leadership and Ownership of Risk

As Georgina's needs increased, multiple agencies were involved in different aspects of her care, including primary care, community health services, adult social care, and commissioned care providers. There is clear evidence that professionals across these services were engaged and responding within their respective roles. However, there is limited evidence that this involvement translated into a coordinated, multi-agency response to her changing needs.

Information about Georgina's situation was held across different services, with carers raising concerns, health professionals providing advice, and family members actively involved in day-to-day care. While actions were taken within individual professional boundaries, there is little indication that these were brought together through a formal mechanism to develop a shared plan or collective understanding of risk. Practitioner reflection highlighted that, in a context where multiple issues were present; declining physical health, mobility concerns, equipment needs, and increasing care demands, there was uncertainty about who should take the lead in coordinating a response. Responsibility for escalation appears to have been diffuse, with no single professional or service clearly identified as holding oversight of Georgina's situation as a whole.

This is consistent with findings from other Safeguarding Adults Reviews involving older adults with complex care needs, where multi-agency involvement has not always resulted in coordinated action. Reviews such as the Adult AP Safeguarding Adults Review (South Tyneside) and the Adult K Safeguarding Adults Review (Lancashire) have identified similar patterns, in which care became fragmented and reactive in the absence of clear leadership or coordinated oversight.⁷

National safeguarding guidance emphasises that where care is delivered across multiple providers, effective coordination and clarity of roles and responsibilities are essential to ensure that risks are identified, shared, and responded to in a timely and proportionate way⁸. Without this, there is an increased risk that important information remains siloed and that no single agency recognises the full picture of an individual's needs. In Georgina's case, while professionals were acting within their roles and seeking to respond to presenting issues, the absence of a coordinated approach meant that opportunities to bring together information, clarify responsibility, and plan collectively were not consistently realised. This limited the system's ability to respond effectively to the complexity of her situation as it evolved. It is important to recognise that this occurred within a context of service pressures and distributed responsibilities across organisations. This finding therefore reflects not a lack of professional commitment, but a system-level challenge in translating multi-agency involvement into coordinated, accountable action.

5.3 Information Sharing, Communication and Escalation

While Section 5.2 highlights the absence of clear coordination and ownership of risk, this section focuses specifically on how information was communicated, interpreted, and escalated across services.

As concerns about Georgina's condition emerged and developed, information was being generated and shared across the system. Carers reported concerns regarding skin integrity and mobility; district nursing services were contacted for advice; general practice was informed; and

⁷ South Tyneside Safeguarding Adults Board (2023) Safeguarding Adults Review: Adult AP; Lancashire Safeguarding Adults Board (2022) Safeguarding Adults Review: Adult K.George; Cumbria Safeguarding Adults Board (2024) Safeguarding Adults Review: Sarah.

⁸ Department of Health and Social Care (2018) Pressure ulcers: how to safeguard adults.

adult social care was involved at points during the period of increasing need. There is therefore evidence that communication did take place between services. However, the available evidence and practitioner reflection suggest that this communication did not consistently translate into a shared understanding of urgency or into timely escalation of risk.

In practice, information often moved sequentially rather than collectively. For example, care staff described passing concerns to district nursing services and awaiting guidance before acting further, reflecting appropriate professional boundaries but also creating delays in response where advice was not immediate or where the significance of concerns was not fully conveyed across agencies. Similarly, safeguarding concerns were raised, but these were initially framed narrowly around a specific issue rather than the wider context of escalating need.

Practitioner reflection indicates that:

- **concerns were communicated, but not always interpreted in the same way across services**
- **escalation thresholds were not consistently understood or applied**
- **there was reliance on indirect communication routes, particularly via family members**
- **opportunities for direct professional-to-professional communication were not always maximised**

This pattern is consistent with findings from previous Safeguarding Adults Reviews, including those conducted in Cumbria, which have highlighted that information sharing alone does not ensure effective safeguarding. Rather, it is the interpretation, contextualisation, and collective sense-making of information that enables appropriate escalation and intervention⁹. National guidance reinforces that effective safeguarding depends not only on sharing information, but on ensuring that concerns are communicated clearly, understood consistently, and acted upon proportionately¹⁰. Where communication is indirect, fragmented, or lacks clarity about urgency, there is an increased risk that deterioration is not escalated at the point at which intervention would be most effective.

In Georgina's case, while there were multiple points at which concerns were raised and communicated, there is limited evidence that these were consistently synthesised into a clear, shared narrative of escalating risk. As a result, escalation did not always occur at the earliest opportunity, and responses remained aligned to individual service perspectives rather than a collective assessment of need. This finding does not suggest that communication was absent. Rather, it highlights a system-level challenge in ensuring that information is not only shared, but also understood, prioritised, and acted upon in a coordinated and timely way.

5.4 The Interface Between Family Care and Professional Support

A central feature of Georgina's care was the significant role played by her daughter in supporting her at home. As Georgina's needs increased, her daughter became responsible for managing increasingly complex care tasks, including repositioning, administering medication, monitoring skin integrity, and coordinating with multiple services. This took place alongside the practical and emotional demands of maintaining the home environment and, as described in practitioner discussions, managing wider responsibilities associated with rural living.

⁹ Cumbria Safeguarding Adults Board (2022) Safeguarding Adults Review: Pauline and George.

¹⁰ Department of Health and Social Care (2018) Pressure ulcers: how to safeguard adults.

There is clear evidence that her daughter was actively engaged in her mother's care and was seeking support from services. However, the evidence also suggests that the interface between family care and professional support was not always clearly defined, consistently understood, or sufficiently supported as Georgina's needs became more complex. Practitioner reflection highlighted that:

- **expectations of what the family could safely manage were not always explicitly explored**
- **the level of skill, knowledge, and physical capacity required to meet Georgina's needs increased rapidly**
- **communication between professionals and the family did not always ensure shared understanding of risk or care requirements**
- **family members were, at times, placed in a position of managing care that would ordinarily require professional input**

Effective prevention and management of pressure ulcers requires regular repositioning, appropriate equipment, clinical oversight, and ongoing reassessment of risk. Guidance from the National Institute for Health and Care Excellence emphasises that individuals at risk should receive structured risk assessment, timely intervention, and coordinated care planning, including support that is proportionate to the level of need¹¹. Where care requirements become complex or intensive, this guidance makes clear that reliance on informal care alone may not be sufficient to maintain safety. In Georgina's case, while advice was provided and services were involved, there is limited evidence that there was a shared, explicit assessment of whether the care being provided at home remained safe and sustainable as her condition deteriorated. The increasing reliance on her daughter to deliver complex care appears to have developed incrementally, rather than through a planned and supported transition.

The use of non-prescribed treatments by the family, while appropriately addressed by professionals at the time, can be understood within this context. Practitioner reflection and safeguarding discussions indicate that this action was not malicious, but reflected a combination of distress, uncertainty, and a perception that needs were not fully being met. This aligns with wider research which highlights that family carers may adopt alternative or improvised approaches where they feel unsupported or where care demands exceed their capacity¹².

Importantly, the evidence also highlights that the family's voice, including expressions of difficulty and requests for increased support, may not always have been fully heard or acted upon in a timely way. This is consistent with findings from previous Safeguarding Adults Reviews, which have identified that family carers' insights can be under-recognised as indicators of escalating risk, particularly where care is being sustained despite increasing strain¹³. At the same time, it is important to recognise the complexity of this context. Georgina's preference to remain at home, the emotional significance of her home environment, and the commitment of her daughter to supporting this were all important factors. Practitioners were therefore working within a tension between respecting autonomy and ensuring safety, which is a recognised challenge in safeguarding practice.

¹¹ National Institute for Health and Care Excellence (2014, updated) Pressure ulcers: prevention and management (CG179).

¹² Cumbria Safeguarding Adults Board (2022) Safeguarding Adults Review: Pauline and George.

¹³ *ibid*

This finding highlights the need for:

- **clearer, ongoing assessment of the sustainability of family-provided care**
- **explicit conversations with families about roles, expectations, and limits**
- **timely adjustment of professional support as needs escalate**
- **recognition of family carers as both partners in care and individuals who may themselves require support**

In Georgina's case, while there was clear commitment from both family and professionals, the interface between informal and formal care did not fully adapt as her needs increased. As a result, care demands appear to have exceeded what could safely be managed within the home environment, without this being collectively recognised and addressed at an earlier stage.

5.5 Safeguarding Framing, Thresholds and Professional Curiosity

During the period of increasing concern, safeguarding processes were initiated. However, the evidence suggests that early safeguarding activity was framed around a specific presenting issue, rather than the wider context of Georgina's escalating needs and circumstances. The initial safeguarding concern focused on the use of a non-prescribed treatment. This was appropriately addressed at the time through advice and corrective action. However, both the case material and practitioner reflection indicate that this issue became the primary lens through which risk was understood, rather than acting as a trigger to explore the broader context of care, including cumulative deterioration, increasing immobility, and the growing demands placed on family care.

As the situation progressed, a further safeguarding referral was made at a later stage, by which point Georgina's condition had significantly deteriorated and hospital admission had occurred. Practitioner reflection suggests that:

- **safeguarding was not consistently used as a mechanism to bring together multi-agency perspectives at an earlier stage**
- **there was uncertainty about when concerns met the threshold for safeguarding beyond individual incidents**
- **the wider context, including carer strain and escalating care complexity, was not fully explored through a safeguarding lens**

This reflects a well-established challenge within safeguarding practice. The Care Act statutory guidance makes clear that safeguarding duties apply not only in response to discrete incidents of harm, but also where there is a risk of abuse or neglect arising from unmet care and support needs¹⁴. This includes situations where individuals are unable to protect themselves due to frailty, ill health, or dependency on others for care.

Research highlights that safeguarding concerns involving older adults often develop cumulatively, rather than through a single triggering event. Their work demonstrates that practitioners may struggle to recognise when a series of lower-level concerns, such as deterioration, carer strain, and unmet need, should prompt a safeguarding response¹⁵. This pattern is also evident in previous

¹⁴ Department of Health and Social Care (2022) Care and Support Statutory Guidance (updated), issued under the Care Act 2014.

¹⁵ Care Quality Commission (2020) The state of health care and adult social care in England; Social Care Institute for Excellence (2018) Safeguarding adults: practice guidance.

Cumbria Safeguarding Adults Reviews, which have identified that safeguarding can become narrowly focused on specific incidents, rather than being used as a framework to explore the broader context of risk¹⁶. These reviews emphasise the importance of professional curiosity and holistic enquiry, particularly in cases involving older adults with complex and escalating needs.

In Georgina's case, while safeguarding processes were eventually engaged, there is limited evidence that they were used proactively to explore the full context of her situation at an earlier stage. The focus on a specific issue, rather than the broader pattern of concern, may have contributed to a delay in recognising the need for a coordinated safeguarding response. Importantly, this finding does not suggest that practitioners failed to act appropriately within the information available to them. Rather, it highlights a system-level challenge in how safeguarding thresholds are understood and applied in practice, particularly in cases where risk develops incrementally and across organisational boundaries.

This finding points to the need for:

- **safeguarding to be used as a framework for holistic enquiry, not solely incident response**
- **greater confidence in applying safeguarding thresholds in situations of cumulative risk**
- **strengthened professional curiosity where concerns appear low-level but persistent**
- **recognition that early safeguarding engagement can support coordination, not just investigation**

In Georgina's case, earlier use of safeguarding as a mechanism for shared understanding may have supported a more timely and coordinated response to her increasing needs.

5.6 Capacity, Decision-Making and Best Interests

Throughout the period under review, there were multiple decision points relating to Georgina's care, including decisions about remaining at home, the level of support required, and responses to her deteriorating physical condition. These decisions were made in a context of increasing complexity, involving both family members and multiple professionals across health and social care. There is evidence that aspects of Georgina's cognitive functioning were considered at different points, including reference to memory concerns and reduced insight. However, the review has identified limited evidence of a clearly documented, shared understanding of her mental capacity in relation to specific decisions about her care and living arrangements during the period of deterioration.

Practitioner reflection suggests that:

- **capacity was considered within individual professional interactions, but not consistently documented or shared across agencies**
- **there was limited evidence of coordinated, decision-specific capacity assessments as Georgina's needs changed**
- **the absence of a Lasting Power of Attorney contributed to uncertainty in decision-making processes**
- **opportunities to convene best interests discussions were not consistently taken at earlier stages**

¹⁶ Cumbria Safeguarding Adults Board (2022) Safeguarding Adults Review: Pauline and George.

The Mental Capacity Act 2005 (MCA) provides a clear framework for supporting decision-making where there are concerns about an individual's ability to make specific decisions. It emphasises that capacity is both decision-specific and time-specific, and that where an individual is assessed as lacking capacity, decisions must be made in their best interests, involving relevant professionals and those close to the person¹⁷. The MCA Code of Practice further highlights the importance of multi-agency involvement in complex cases, particularly where decisions involve significant risks or changes in care arrangements¹⁸. Best interests decision-making is intended to provide a structured forum for considering the person's wishes, feelings, and values, alongside professional assessment of risk and need.

In Georgina's case, while there were indications that her ability to understand and weigh decisions may have been affected, there is limited evidence that this was consistently translated into formal, shared decision-making processes. The absence of clearly documented, multi-agency best interests discussions during the period of escalating need meant that decisions about her care appear to have been made incrementally, rather than through a coordinated and transparent framework. This is consistent with findings from wider research, which has identified that in complex cases involving older adults, capacity assessments may be undertaken in isolation, without being effectively shared or used to inform collective decision-making¹⁹. This can lead to uncertainty about who holds decision-making responsibility and can delay timely intervention where risks are increasing.

At the same time, it is important to recognise the complexity of the context. Georgina's expressed wishes to remain at home, the involvement of her family in supporting this, and the challenges associated with rapidly changing health needs all contributed to a dynamic and evolving decision-making environment. Practitioners were required to balance respect for autonomy with considerations of safety, often within limited or incomplete information.

This finding highlights the importance of:

- **clear, decision-specific capacity assessments that are documented and shared across agencies**
- **timely use of best interests processes in situations of escalating risk**
- **multi-agency collaboration in complex decision-making**
- **ensuring that capacity considerations are revisited as circumstances change**

In Georgina's case, a more consistent and coordinated application of the Mental Capacity Act framework may have supported clearer decision-making and earlier consideration of alternative care arrangements as her needs increased.

6. Areas of Positive Practice

While this review has identified areas where practice could have been strengthened, it is equally important to recognise the commitment, compassion, and professionalism demonstrated by those involved in supporting Georgina. Across the period under review, practitioners were working within

¹⁷ Mental Capacity Act 2005.

¹⁸ Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice.

¹⁹ Manthorpe, J., Samsi, K., & Rapaport, J. (2013) "Capacity is key": investigating new legal provisions in England and Wales for adult safeguarding, *Journal of Elder Abuse & Neglect*.

a complex and evolving situation, characterised by rapidly changing needs, multiple agencies, and a challenging family context. Within this, there were clear examples of positive practice.

6.1 Commitment to Supporting Georgina at Home

There was a consistent effort across services to respect Georgina's wishes to remain at home for as long as possible. Practitioners sought to balance these wishes with the practical realities of her increasing care needs, reflecting a person-centred approach in line with the principles of the Care Act. Care staff, in particular, demonstrated persistence and adaptability in supporting Georgina within the home environment, often working in difficult circumstances and responding to emerging needs as they arose.

6.2 Responsiveness to Emerging Clinical Concerns

There is evidence that practitioners responded to concerns as they became aware of them. This included:

- seeking advice from district nursing services
- requesting GP input and home visits
- adjusting pain management as Georgina's condition changed
- escalating concerns as her condition deteriorated

These actions indicate that individual practitioners were attentive to changes in Georgina's condition and took steps within their roles to respond appropriately.

6.3 Compassionate End-of-Life Care

Following hospital admission and transition to a care setting, there was evidence of coordinated efforts to support Georgina at the end of her life. Practitioners recognised the transition to end-of-life care and ensured that appropriate measures were in place, including:

- review of pain management
- implementation of anticipatory care planning
- efforts to involve family members despite relational challenges

Evidence from the review indicates that Georgina was supported to experience a peaceful and dignified death, with opportunities for family members to spend time with her.

6.4 Professional Reflection and Learning

A notable strength identified through the review process was the openness and willingness of practitioners to reflect on their practice. The practitioner learning event was characterised by honest and thoughtful reflection on challenges, recognition of areas for improvement and a commitment to applying learning to future practice. This culture of reflective practice is a key component of effective safeguarding systems and provides a strong foundation for embedding the learning identified within this review.

6.5 Person-Centred Practice within Adult Social Care

There is evidence within Adult Social Care practice of a clear intention to work in a person-centred way, particularly in relation to understanding and responding to Georgina's expressed wish to remain at home.

Practitioner reflection indicates that the allocated social worker maintained a consistent focus on Georgina's preferences, and efforts were made to support her to remain at home as her needs increased. This reflects an approach aligned with the principles of the Care Act, with an emphasis on respecting autonomy and supporting individuals to live in the least restrictive way possible. There is also evidence of collaborative working between Occupational Therapy and Social Work, with practitioners engaging with one another to respond to the situation as it presented.

Taken together, this suggests that practice was well-intentioned and grounded in a commitment to person-centred care, with professionals seeking to balance Georgina's wishes alongside the practical challenges of supporting her at home.

7. Recommendations

The following recommendations are designed to support system-wide learning and improvement. They are informed by the findings of this review, practitioner reflection, and relevant evidence and policy frameworks. They are intended to strengthen multi-agency practice in recognising and responding to escalating need in adults with complex health and care requirements.

Recommendation 1: Early Multi-Agency Review in Response to Deterioration

Safeguarding partners should ensure that rapid or cumulative deterioration (including reduced mobility, emerging pressure damage, or increasing care needs) triggers an early multi-agency review, rather than being managed within single services.

This should include:

- clear local guidance on when deterioration should prompt a multi-agency discussion (e.g. MDT, safeguarding discussion or equivalent)
- an explicit expectation that no single agency is left to manage escalating risk in isolation
- clarity about who is responsible for initiating escalation, particularly where multiple agencies are involved
- use of existing forums (e.g. ICC or MDT structures), with alternative arrangements in place where these are not accessible

This reflects learning from previous Cumbria Safeguarding Adults Reviews, including the Pauline and George SAR, which identified similar challenges in recognising and responding to cumulative deterioration. This recommendation therefore focuses on strengthening the consistent application of existing learning, rather than introducing new processes.

Assurance:

The Board should seek assurance through audit of cases involving rapid or cumulative deterioration, including whether multi-agency discussions were convened at an early stage and whether escalation pathways were clearly understood and applied.

Recommendation 2: Strengthening Prevention and Escalation of Pressure Damage

Health and care partners should ensure that the development or risk of pressure damage in community settings triggers a clearly defined escalation pathway, particularly where care is being delivered with support from family carers.

This should include:

- ensuring early, proactive conversations with individuals and family members when mobility begins to decline, including discussion of pressure ulcer risk, repositioning, and whether existing care arrangements remain sufficient
- ensuring timely referral to tissue viability services where pressure damage is identified or suspected
- clear and consistent communication of repositioning requirements, skin care, and care expectations to both care providers and family members
- direct communication between district nursing services and care providers, reducing reliance on indirect or second-hand information
- active review of whether equipment, care packages, and support arrangements remain sufficient as needs increase

This reflects practitioner learning that concerns about skin integrity were raised, but escalation pathways were not always clear, communication did not consistently reach the appropriate professionals directly, and increasing care complexity was not always matched by increased support. This is consistent with national clinical guidance, including National Institute for Health and Care Excellence guidance²⁰ on pressure ulcer prevention and management, which emphasises early identification, proactive intervention, and coordinated care. This includes ensuring that practitioners have confidence in recognising early signs of pressure damage and understanding when escalation is required.

Previous Safeguarding Adults Reviews have similarly identified the need for earlier recognition and escalation of deterioration linked to pressure damage. This case indicates that while awareness of this issue exists, its application in practice remains inconsistent.

Assurance:

The Board should seek assurance through audit of cases involving pressure damage, including evidence of timely referral to tissue viability services, clear communication between professionals, and appropriate escalation where care needs increase. This should include consideration of feedback from carers and service users to understand how care is experienced in practice and whether concerns are recognised and responded to appropriately.

Recommendation 3: Strengthening Direct Communication and Escalation Between Services

Safeguarding partners should strengthen expectations for direct, timely communication between

²⁰ National Institute for Health and Care Excellence (2014, updated) Pressure ulcers: prevention and management (CG179). London: NICE.

care providers, district nursing services, and primary care in complex cases, ensuring that concerns are clearly understood, acted upon, and followed through.

This should include:

- reducing reliance on family members to relay clinical information, with communication taking place directly between professionals
- ensuring care providers are able to escalate concerns directly and receive timely, outcome-focused responses
- clarifying escalation routes where advice is sought but concerns persist, including what action should be taken if responses are not received or are insufficient
- ensuring that repeated concerns are recognised as indicators of escalating risk, rather than managed as isolated contacts

This reflects practitioner learning that concerns were communicated but not always consistently understood, actioned, or followed through, and that care staff at times felt constrained by unclear escalation pathways and professional boundaries. Previous Safeguarding Adults Reviews have consistently identified fragmented communication and indirect information-sharing as a recurring theme. This recommendation therefore focuses on strengthening the consistent application of existing communication and escalation pathways in practice.

Assurance:

The Board should seek assurance through audit and practitioner feedback that communication between services is direct, timely, and results in clear actions, including evidence that repeated concerns are recognised and appropriately escalated.

Recommendation 4: Supporting and Safely Framing Family-Delivered Care

Safeguarding partners should ensure that where family members are providing significant care, there is ongoing, explicit assessment of the safety, sustainability, and clinical appropriateness of those arrangements, particularly as needs increase.

This should include:

- clear, documented conversations with families about what care is required and what can realistically and safely be provided
- ensuring families receive practical, skills-based guidance (e.g. repositioning, medication administration, use of equipment), with opportunities to check understanding
- recognising the impact of increasing care demands on both family members and professional carers, and ensuring opportunities for reflection, support, and escalation where concerns arise
- recognising carer strain, distress, or difficulty managing care as indicators of escalating risk, rather than solely support needs
- regular review of whether care arrangements remain safe and appropriate, including when needs increase rapidly or exceed what can reasonably be managed within a family setting

This reflects practitioner learning that care demands increased rapidly, expectations of the family role were not always clearly defined, and signs of distress and difficulty may have indicated unmet

need and increasing risk, rather than being fully recognised as such. Previous Safeguarding Adults Reviews have consistently highlighted the importance of recognising carer capacity and the limits of family-delivered care. This case reinforces the need to apply this learning consistently in practice.

Assurance:

The Board should seek assurance through audit of cases involving family-delivered care, including evidence of carer assessment, clear communication of care expectations, and timely review where care demands increase.

Recommendation 5: Strengthening Application of the Mental Capacity Act

Safeguarding partners should ensure consistent and robust application of the Mental Capacity Act 2005, particularly in complex and deteriorating situations where care needs are increasing and decisions about care, treatment, or living arrangements are required.

This should include:

- undertaking and recording decision-specific capacity assessments, with clear rationale, and ensuring these are shared appropriately across agencies;
- timely use of best interests decision-making processes, particularly where there is uncertainty, disagreement, or increasing risk;
- ensuring that capacity is reviewed as circumstances change, rather than assumed to remain static;
- clarity about how capacity decisions inform care planning and escalation, including when care arrangements may no longer be safe or appropriate.

This reflects practitioner learning that capacity was considered but not always clearly documented, shared, or revisited, and that opportunities for earlier 'best interests' decision-making were missed as needs escalated. Previous Safeguarding Adults Reviews have consistently identified inconsistent application of the Mental Capacity Act 2005 as a recurring issue. This recommendation therefore focuses on strengthening shared understanding, documentation, and practical application in multi-agency contexts.

Assurance:

The Board should seek assurance through audit of cases involving complex or deteriorating need, including evidence of decision-specific capacity assessments, timely 'best interests' decision-making, and effective information-sharing across agencies.

Appendix A – Comparable SARs

The table below summarises a small number of comparable reviews that involve older adults, pressure ulcers or severe skin-integrity concerns, deterioration, discharge, and multi-agency safeguarding issues. It is included to situate Georgina's case within the wider learning landscape and to support consideration of whether known learning has been embedded locally.

Table 2 Comparable Safeguarding Adults Reviews and Reviews Involving Older Adults, Pressure Ulcers / Skin Integrity, and Deterioration

SAR / Review	Context	Key issues	Key learning	Recommendations
Cumbria SAB – Pauline & George	Pauline was in her late eighties, living at home and heavily reliant on George as her main carer; both had health needs. This is not a pressure-ulcer SAR, but it is the closest published Cumbria comparator for older adult deterioration, dependence on family care, and escalation of need.	Increasing frailty and dependency; carer strain; reliance on one family carer; risk not always understood holistically; questions about practice responses and strategic responses.	Older adults' deterioration and family-carer strain can become normalised; agencies may respond to individual presenting issues without fully appreciating cumulative risk across the whole care situation.	Strengthen recognition of deteriorating need; improve multi-agency responses where care relies heavily on an informal carer; embed strategic learning on escalation and safeguarding responses.
South Tyneside SAB – Adult AP	SAR triggered by the development of significant pressure ulcers and concerns about how agencies worked together.	Pressure damage; care at home / in the community; multi-agency working; whether deterioration and risk were recognised and acted on early enough.	Severe pressure damage is rarely a single-issue problem; it often signals wider deterioration, unmet need, and failures in coordinated oversight.	Earlier escalation when pressure damage emerges; better multi-agency oversight; improved coordination and review of changing needs.
Lancashire SAB – Adult K	Older adult admitted to hospital in a poor state of health; report records a Grade 2 pressure ulcer, declining health, and heavy reliance on his wife.	Self-neglect features; pressure ulcer; poor living conditions; carer strain; capacity; best interests; fragmented and reactive agency response.	Deterioration, pressure damage, carer stress, and refusal of care must be seen together; care at home can become unsafe when no one stands back and reviews the whole picture.	Earlier best-interests / MCA use; improved joint working; earlier care planning and escalation where home care is no longer safe or sustainable.

SAR / Review	Context	Key issues	Key learning	Recommendations
Berkshire West SAB – P	Woman aged 63 with multiple sclerosis and scoliosis; family raised concerns about worsening contractures and severe pressure ulcers before her death. Not elderly, but highly relevant on pressure-ulcer deterioration and systems failure.	Severe pressure ulcers; contractures; family concerns; safeguarding concerns about care setting; whether agencies protected her effectively.	Pressure-ulcer cases often involve interaction between deterioration, positioning / contractures, family concern, and care-system failure; family concerns need to be taken seriously as part of the risk picture.	Better recognition of deteriorating skin integrity; stronger safeguarding responses where severe ulcers develop; improved coordination between care providers, commissioners and health services.
Islington SAB – AA	Mr AA was 84 and had repeated hospital admissions for pressure ulcer care before his death.	Failure to spot early warning signs; failure to recognise increasing care and support needs; poor hospital discharge planning; MCA concerns.	Pressure ulcers are often preventable; professionals need to understand the links between skin integrity, hydration, continence and mobility; discharge without proper planning can increase risk significantly.	Improve staff understanding of early pressure-ulcer signs; strengthen discharge planning; ensure MCA is used properly when people refuse necessary care.
Norfolk SAB – Adult R	Older woman returned home after a stroke and received bed-based care at home; she was in great pain with pressure sores and later died from sepsis and an infected sacral ulcer.	Post-stroke deterioration; bed-based care at home; severe pain; skin breakdown; whether home care arrangements were safe and sufficient.	Returning home in line with a person's wishes still requires active review of whether care arrangements are clinically and practically safe; pressure sores may indicate that care needs have outstripped support.	Improve oversight of home-based bed care; earlier review of pressure damage and pain; stronger joined-up planning where a person's needs change rapidly after discharge.

SAR / Review	Context	Key issues	Key learning	Recommendations
Hillingdon Safeguarding Partnership – Rachel	Woman aged 85 living at home with a care package and community healthcare; during a two-month period she developed a pressure ulcer and died from sepsis secondary to an infected pressure ulcer.	Rapid deterioration at home; pressure ulcer development; interface between care package and community health care; whether escalating risk was recognised and acted on.	Pressure-ulcer deterioration in the community may happen quickly; care-package input and community-health input need active coordination, not parallel working.	Better coordination between domiciliary care and community health; earlier escalation when skin integrity deteriorates; closer oversight of home care where needs are increasing.
Wolverhampton SAB – Edith	Overview report for an 80-year-old adult; diagnosis included sepsis secondary to community acquired pneumonia and infected pressure ulcers.	Deterioration; infected pressure ulcers; identifying next of kin / family communication; escalation and end-of-life decision-making.	Pressure-ulcer cases often sit within a wider context of frailty, deterioration, communication problems, and uncertainty over escalation.	Better recognition of deterioration; improved communication and family contact information; clearer escalation and end-of-life planning.