WOLVERHAMPTON SAFEGUARDING TOGETHER

## Safeguarding Adults Review published

Released: Friday 16th May 2025

A Safeguarding Adults Review has today been published by Wolverhampton Safeguarding Together.

The review was commissioned to examine in detail the experiences of Patrick, a man in his 50s, who lived with his wife and brother-in-law. He had a diagnosis of schizophrenia, a learning disability and a hearing impairment, and was sadly found dead at his home in April 2024.

Prior to his death, he had received support from a number of services including the Community Psychiatric Nursing Service, the District Nursing Service, the Phlebotomy Service, Primary Care Home Visiting Service and Adult Social Services.

The review makes four recommendations to Wolverhampton Safeguarding Together:

- The partnership should undertake a piece of work to understand the barriers and enablers to identifying self-neglect and hoarding and the challenges for professionals in convening multi-disciplinary teams across the partnership.
- The partnership should review the training provided about the tools for self-neglect and hoarding and consider whether this requires further action to embed the use of the tools across the partnership.
- The partnership should seek assurance that professional curiosity and the Think Family approach are promoted, encouraged and supported by its member agencies.
- The partnership should review the training provided about the Mental Capacity Act 2005 and consider whether any further action is needed to support an improved understanding across the partnership.

Alison Hinds, Chair of Wolverhampton Safeguarding Together Executive Board, said: “This was a very sad case, and we would like to extend our condolences to Patrick’s wife, and everyone else who knew him.

“The purpose of commissioning this Safeguarding Adult Review is to ensure that we, as a safeguarding partnership, can take action to address any shortfalls in practice which are identified.

"The review has taken a systemic approach in its examination of the key lines of enquiry, using Patrick's circumstances as a lens through which to also consider wider adult safeguarding practice undertaken in Wolverhampton.

"As a safeguarding partnership we welcome the recommendations that have been made and have initiated an action plan to ensure that we are able to act upon them."

The Safeguarding Adults Review has been published on the Wolverhampton Safeguarding Adults Board website. For more information, please visit www.wolverhamptonsafeguarding.org.uk.

**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 Together Board provides strategic leadership for 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.