BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

SAR Karla
Executive Summary

Contents

This Executive summary was produced by Ash Manzoor Board Business Manager – Birmingham Safeguarding Adults Board

Confidentiality

In order to protect the identity of the individuals featured within the review, all names have been anonymised, and the adult will be referred to as Karla

Purpose

This SAR was commissioned by Birmingham Safeguarding Adults Board to examine the circumstances surrounding the death of Karla's death in order to identify learning and improve services in the future.

Introduction

This is the Executive summary of a SAR report commissioned by the Birmingham Safeguarding Adult Board (BSAB) following a Safeguarding Adults Review (SAR).

Background to the Safeguarding Adults Review

The Birmingham Safeguarding Adults Board (BSAB) has a statutory duty to arrange a Safeguarding Adults Review (SAR) when the Criteria for a SAR is met. The SAR Sub-group of the BSAB Executive Board considered this case against the SAR criteria and agreed the case met the statutory criteria for a SAR. The Independent Chair of the BSAB agreed with this decision. It was decided to commission someone independent to carry out the review and use reflective learning sessions as a methodology for the review.

For the preserve anonymity the adult has been given pseudonym of Karla.

What happened

Karla was a 52-year-old white British woman with complex physical and mental health needs, including Emotionally Unstable Personality Disorder and chronic health conditions. She was a wheelchair user and had a long history of trauma and service involvement, yet her care remained fragmented.

Despite frequent hospital attendances and being known to multiple services, Karla declined formal support under the Care Act and relied heavily on informal carers. In late 2021, her health deteriorated significantly—she became malnourished, developed severe pressure ulcers, and was increasingly dependent on her family, who struggled to meet her needs.

A safeguarding referral was made during her final hospital admission, where concerns were raised that she was being neglected. Family members reported her declining mental and physical health to hospital staff. These concerns were not reflected in the records of professionals who were visiting her daily. Karla died in hospital in December 2021, with her death certificate citing stroke.

Methodology

The methodology for this review was based mainly on a Reflective Practice Session and information from scoping. Professionals from organisations involved with Karla including frontline practitioners were invited to take part in a reflective practice session.

Due to the review taking place sometime after Karla's death some of the key front-line staff were no longer available, therefore their respective organisations were asked to send an appropriate representation to participate in the Reflective Practice Session.

The aim of the sessions was to consider the professional involvement and partnership work from the multiple agencies whom Karla was known to and identify any system learning.

The face-to-face Reflective Practice session was facilitated by an independent lead reviewer and sought to establish facts and details, in addition to summary information provided by each agency, arising from their involvement in Karlas life.

Following the Reflective Learning Sessions the Independent Lead reviewer was asked to draft a short Overview Report, overseen by the SAR Subgroup. An Overview Report was to bring together all the relevant information provided to the independent reviewer by all contributing agencies and respond to the agreed terms of reference.

Key Learning Points

The review identified missed opportunities for coordinated care, insufficient recognition of self-neglect, and a lack of trauma-informed approaches. It highlights the need for improved multi-agency collaboration, professional curiosity, and support for informal carers.

Learning Point: Recognition of Self-Neglect – Despite multiple indicators, Karla was not identified as experiencing self-neglect, limiting the use of safeguarding procedures under the Care Act 2014.

Learning Point: Professional Curiosity – A lack of professional curiosity led to missed opportunities for holistic care and safeguarding.

Learning Point: Trauma informed Practice – Professionals dealing with presenting issues to be aware of how trauma or past experiences could impact the adult from engaging. Organisations should continue to provide Trauma Informed Training and development opportunities for their staff.

Learning Point: There is complex interplay between trauma/mental health and mental capacity that needs to be given careful consideration by professionals supporting individuals. Any consideration should be carefully documented on the person's records and include ways in which risks posed to the person because of unwise decisions where the person is deemed as having mental capacity may be mitigated against.

Learning Point: Professionals supporting individuals with complex health and trauma histories benefit from regular reflective supervision. This promotes holistic, critical thinking about how trauma and mental health affect decision-making and risk. In Karla's case, such supervision across agencies may have improved coordination and strengthened support.

Learning Point: Help-seeking and rejecting behaviours are linked to Personality Disorder (PD) and can reduce life. Professionals and organisation should work towards understanding interplay between PD and comorbidities, risk of harm, and the use of effective multi-agency partnership working as a means of effectively mitigating these risks.

Learning Point: Support for Informal Carers – Carers' assessments were not consistently offered or followed up, despite clear signs of carer strain.

Learning Point: Continuity of Care – Delays in discharge documentation and referrals impacted continuity of care, particularly in pressure ulcer management.

Learning Point: Conducting multi-agency meeting– Where practitioners are struggling to engage an individual, they should consider convening a multi-disciplinary team meeting (MDT) to support coordinated intervention.

Learning Point: Repeated unwise decisions that place a person at serious risk should prompt professionals to question mental capacity. In Karla's case, limited professional curiosity may have missed how EUPD affected her ability to weigh decisions about care.

Learning Point: There were delays in reinstatement of pressure ulcer care due to possible delays of the hospital informing the district nurse service.

Recommendations:

Recommendation 1: UHB and BCHC to review hospital discharge processes to prevent delays in community care reinstatement.

Recommendation 2: BSAB to undertake audits to identify if practitioners know how to respond to signs of self-neglect.

Recommendation 3: BSAB to seek assurance that the Self-Neglect Pathway is understood and used effectively by CMHT, Adult Social Care, UHB, BCHC, and Primary Care.

Recommendation 4: BSAB and partners to continue to raise awareness of trauma informed practice.

Recommendation 5: The Board seek assurance that organisations recognise the needs of informal carers and understand the referral pathway for a Carers Assessment.

BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

Website: www.bsab.org