

1. What happened?

Adult F was a 51-year-old female with learning difficulties and hearing impairment, living alone when she died from pneumonia. She was a victim of domestic abuse and became a mother young, subsequently her 4 children were removed from her care. She had a long-standing history of alcohol dependency and was supported by her mother who also had care and support needs. In the months leading to her death there were increasing concerns about her social isolation, self-neglect, alcohol use, weight loss and that she was declining services.

Glossary: Learning Difficulties (LD)

2. Learning from the review

Adult F was largely invisible - her voice was mainly heard through professionals' communication with her mother, this was good intentions but reinforced Adult F's lack of independence and meant Adult F was seen only very rarely. Professionals struggled to achieve a relational approach to 'find the person'.

Adult F's mother managed her daughter's benefits and removed her phone - Professionals could have been more curious about the dynamics of their relationship and considered if mother needed a carers assessment. Adult Social Care's response to 2 safeguarding referrals was delayed and ended prematurely with insufficient fact finding, without any risk assessment, protection plan, review, management oversight, or formal closure. Adult F could have been referred to the High Intensity User Group and Making Every Adult Matter (MEAM) MDT. Professionals could have provided advice about alcohol use support available locally.

7. Resources

[Multi-Agency-Professionals-Meetings-Guidance-Sep-2022](#)

[Calderdale Self-Neglect Guidance 2023](#)

[Working with Non-Engaged Adults Guidance](#)

[Calderdale Multi-Agency Safeguarding Adults Policies and Procedures](#)

[Mental Capacity Guidance](#)

[Calderdale Resolving Professional Disputes](#)

[Professional curiosity](#)

3. Learning from the Review

The evidence of self-neglect was mounting but the opportunity to conduct a multi-agency risk assessment was missed as was the opportunity to assess Adult F's needs during a hospital admission. Adult F's low weight, indications of malnutrition & skeletal appearance could have led to a stronger focus on her physical health needs.

4. Recommendations

1. Recognise the importance of consent to use a third party as a means of communication and the implications on successful engagement with the individual.
2. Review support for victims of rape with learning difficulties / hearing impairment
3. GP pathways to support patients with LD getting prescriptions
4. GPs develop pathways to review patients with LD who have missed appointments and have indications of risk of harm
5. Identify reasonable adjustments used by fire Services when supporting people with LD
6. Highlight the importance of multi-agency risk assessments and recognising carer roles and support for carers

5. Recommendations

7. Mental capacity Act training includes executive functioning
8. Review understanding around safeguarding duties under section 42 where there is no consent
9. Review the processes of Adult Services in respect to timeliness, information gathering, risk assessment & response to referrals
10. Assurance around housing support for people adjusting to general needs tenancies.
11. Review effectiveness of support for patients who self-neglect
12. Consider the professional approach to suicidal ideation in cases of serious self-neglect
13. Consider the potential long term impacts on parents of the removal of their children
14. Ensure agencies are aware of the availability of support for people misusing alcohol and their families
15. Promote the use of escalation and challenge as a positive intervention

6. Good Practice

YAS and Police call takers responded with patience and compassion to the large number of 999 calls Adult F made.

The Police transported Adult F to hospital when YAS were unable to do so because of critical demand levels.

Together Housing developed a comprehensive plan to escalate concerns about Adult F, adopted a persistent, flexible and compassionate approach, advocated for her during one of Adult F's hospital admissions, and their process for case closure require management and safeguarding team involvement.

