Safeguarding Adult Review - Adult F

November 2024

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.

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

All professionals should understand the importance of describing behaviours clearly and to use correct terminology when referring to sexual criminal offences, irrespective of any concerns around capacity. Professionals should understand the need to be clear when referring to inappropriate sexual behaviour so as to ensure that relevant and sufficient risk assessment can be completed.

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

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