Chart

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**7. Resources**

[Multi-Agency-Professionals-Meetings-Guidance-Sep-2022](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafeguarding.calderdale.gov.uk%2Fwp-content%2Fuploads%2F2022%2F11%2FMulti-Agency-Professionals-Meetings-Guidance-Sep-2022.pdf&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666384972%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=TVT2acDCzqsg5rM42KAZ8EVXE0bsv0g3FQeCLcyONzY%3D&reserved=0)

[Calderdale  Self-Neglect  Guidance 2023](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafeguarding.calderdale.gov.uk%2Fwp-content%2Fuploads%2F2023%2F11%2FCSAB-Self-Neglect-Guidance-2023.docx&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666419334%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=AVZbSmAcuPhmM1Xx24QA16B1w7f0SPKynHo4yZ9yJXU%3D&reserved=0)

[Working with Non-Engaged Adults Guidance](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafeguarding.calderdale.gov.uk%2Fwp-content%2Fuploads%2F2024%2F05%2FWorking-with-Non-Engaged-Adults-Guidance.pdf&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666436913%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=I5PVsgZojpZw%2BDT%2BYjrUZfEdub%2FU9LK1TLJPqZNoNdQ%3D&reserved=0)

[Calderdale Multi-Agency Safeguarding Adults Policies and Procedures](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwynyy-calderdale.trixonline.co.uk%2Fchapter%2Fmanaging-concerns-involving-a-person-in-position-of-trust-pipot&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666452268%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=qbyR6F1DmvVt7AciaRwvoDnypnquCIFKl7LzcmR1diI%3D&reserved=0)

[Mental Capacity Guidance](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafeguarding.calderdale.gov.uk%2Fadults%2F&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666467312%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=ycmMLlTsTGLFficIIvq69ndjXN%2Bu%2FEIFfwIISuNWFik%3D&reserved=0)

[Calderdale Resolving Professional Disputes](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafeguarding.calderdale.gov.uk%2Fprofessionals%2Fresolving-professional-disputes%2F&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666481595%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=Hjjjb20o7Usaot%2Fzph1X7YdqMuZVZV%2F3820R8KhfE0M%3D&reserved=0)

[Professional curiosity](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwynyy-calderdale.trixonline.co.uk%2Fchapter%2Fprofessional-curiosity&data=05%7C02%7CJulia.Caldwell%40calderdale.gov.uk%7Cc071da23647845fb215508dd4b59aa3b%7C07162ea21b0e498fbb555b41fd4dce4f%7C1%7C0%7C638749570666495262%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=r2YzIbJXWORtZ45yW0pgrbiMGdRS6khVRp35svy7Qyk%3D&reserved=0)

**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

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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)*

**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.

**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.

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**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

**Adult F**

**Safeguarding Adult Review**

**November 2024**

**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.

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